

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02494

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>28 HRS.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>RT. #4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First <b>MARY</b>		Middle <b>L.</b>		Last <b>AARON</b>		4. DATE OF DEATH <b>MARCH 19 1959</b>		Month <b>MARCH</b>		Day <b>19</b>		Year <b>1959</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 27, 1890</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b>		IF UNDER 24 HRS. Days <b>68</b>		Hours <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>				11. BIRTHPLACE (State or foreign country) <b>PENNA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph H. BENJAMIN WELLER</b>						14. MOTHER'S MAIDEN NAME <b>LAURA WERTZ</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-05-7175</b>				17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction, post-260x</b> DUE TO <b>antecedent &amp; Hypertensive Cardio-vascular disease</b> DUE TO <b>Diabetes mellitus</b> DUE TO <b>Diabetes mellitus</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3.7</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1 Jan. 1950</b> , to <b>19 Mar. 1959</b> , that I last saw the deceased alive on <b>19 Mar. 1959</b> , and that death occurred at <b>12:40P M.</b> from the causes and on the date stated above.															
ACTUAL SIGNATURE <b>W. Alfred V. Ormer</b>				M.D. <b>122 S. Centre St.</b>				ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>				DATE SIGNED <b>21 Mar. 59</b>			
PHYSICIAN'S NAME (Type) <b>W. A. VAN ORMER</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/22/59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				ADDRESS <b>Cumberland Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 23 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2501  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>37 DAYS</b>		d. STREET ADDRESS <b>719 MARYLAND AVENUE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>VIRGINIA Clara AFRICA</b>		4. DATE OF DEATH Month Day Year <b>MARCH 14 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 6, 1906</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE S. EASTON</b>		14. MOTHER'S MAIDEN NAME <b>LULA A. EVERSOLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE</b>		18. MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma metastatic</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, colon spreading to bones</b> (c) <b>and lungs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1954</b> , to <b>14 Mar, 19 59</b> , that I last saw the deceased alive on <b>14 Mar, 19 59</b> , and that death occurred at <b>2:25 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Carlton Brinsfield</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>232 Baltimore Ave. 3-14-59</b>	
PHYSICIAN'S NAME (Type) <b>DR. CARLTON BRINSFIELD</b>		<b>Cumberland Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-22-32

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

Reg. No.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DIAGNOSIS

SYMPTOMS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02496

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

2570

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>3yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>			d. STREET ADDRESS <b>65 E. Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Nelson Junior Albright</b>			4. DATE OF DEATH Month <b>Mar</b> Day <b>29</b> Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-2-1934</b>	9. AGE (In years last birthday) <b>25</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>P &amp; K Garage</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Nelson Wm. Albright</b>			14. MOTHER'S MAIDEN NAME <b>Leona Fazenbaker</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-28-9967</b>		17. INFORMANT <b>Mr. Robert Garlock Rt.#2 Zihlman,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RT Cerebral Hemorrhage</b> <b>754.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture of Congenital Anomalous of RT Meningeal Artery</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 hrs</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>W O M Lane</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Mar 30 1959</b>	
EXAMINER'S NAME (Type) <b>W O M Lane M.D. Asst</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-1-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Fort Ashby W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Whiteside</b>		ADDRESS <b>Hafer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>APR 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Amended - 12.5

2505  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>10/13/1944</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Susan</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/20/1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Laundry Worker, Laundry</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Levi Albright</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Koontz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>V NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Myocardial Insufficiency</b> <b>4222</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Arthritis Deformans</b>		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile deterioration</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/1/52</b> , 19____, to <b>3/6/59</b> , 19____, that I last saw the deceased alive on <b>3/5/59</b> , 19____, and that death occurred at <b>1:55 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		ADDRESS (Street, city or town, state) <b>49 Green St.</b> DATE SIGNED <b>3/6/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 9, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 9 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b <b>02 CUMBERLAND,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1003 Harding Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>WILLIAM</b> Last <b>ALDERTON</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1907</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Davis, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry E. Alderton</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Edwards</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-4982</b>	
17. INFORMANT <b>Mrs. Helen A. Alderton</b>		Address <b>Cumberland, Md.</b> <b>1003 Harding Ave.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-16-59</b> to <b>3-5-59</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>3:45A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>122 So. Centre St., Cumberland, Md.</b> DATE SIGNED <b>Charles L. George</b>			
ACTUAL SIGNATURE <b>W. F. Williams M.D.</b>		PHYSICIAN'S NAME (Type) <b>W. F. Williams M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		24a. REC'D BY REGISTRAR <b>MAR 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of burial place		17. Signature of burial place		18. Signature of burial place	
19. Signature of burial place		20. Signature of burial place		21. Signature of burial place	
22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place	
28. Signature of burial place		29. Signature of burial place		30. Signature of burial place	
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52. Signature of burial place		53. Signature of burial place		54. Signature of burial place	
55. Signature of burial place		56. Signature of burial place		57. Signature of burial place	
58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place	
64. Signature of burial place		65. Signature of burial place		66. Signature of burial place	
67. Signature of burial place		68. Signature of burial place		69. Signature of burial place	
70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place	
76. Signature of burial place		77. Signature of burial place		78. Signature of burial place	
79. Signature of burial place		80. Signature of burial place		81. Signature of burial place	
82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place	
88. Signature of burial place		89. Signature of burial place		90. Signature of burial place	
91. Signature of burial place		92. Signature of burial place		93. Signature of burial place	
94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place	
100. Signature of burial place		101. Signature of burial place		102. Signature of burial place	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02499

2507

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
BM 2/57

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Constitution Park</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>242 N. Mechanic St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>ROBERT C. AMAN</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>March 10, 19 59</u> Month Day Year											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 21, 1910</u>		<b>9. AGE</b> (In years last birthday) <u>48</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Meat Cutter</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>A. &amp; P. Market</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>George W. Aman, Sr.</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Mackart</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>214 05 5744</u>				<b>17. INFORMANT</b> <u>Mrs. Emma Aman, Cumberland, Md.</u> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitarelic</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME (Type)</b> <u>Benedict Skitarelic, M.D.</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <u>March 10, 1959</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>3/13/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peter &amp; Pauls Cem.</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Cumberland, Md.</u> <b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Byron Knight</u>						<b>ADDRESS</b> <u>Cumberland, Md.</u>						<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hanna</u>	
<b>DATE</b> <u>Mar 16 '59</u>															



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03757

2508

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>6 HRS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75x-3</b> ✓ d. STREET ADDRESS <b>RT. #1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>BOY</b> Last <b>ARNOLD</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 23, 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>6</b> Months <b>8</b> Days <b>6</b> Min.
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES D. ARNOLD</b>		14. MOTHER'S MAIDEN NAME <b>MARILOU ARNOLD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>761.5</b> DUE TO <b>Prematurity - 32-33 wks.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Uterine infection</b> DUE TO <b>Partial separation of P lacenta</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 23 1959</b> , to <b>Mar 23 1959</b> , that I last saw the deceased alive on <b>Mar 23 1959</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.R. Hodges</b>		ADDRESS (Street, city or town, state) <b>Cumberland, Md</b> DATE SIGNED <b>3/25/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. W. ROYCE HODGES</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bedford Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bedford, Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Gessel</b>		24a. REC'D BY REGISTRAR <b>Bedford, Pa</b> DATE <b>MAY 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

2060313XV2

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

IN THE CITY OF BALTIMORE

DECEASED

NAME

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

2586

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>	c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>L.</b> Last <b>Beal</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13, 1877</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Palo Alto, Pa.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Beal</b>	
14. MOTHER'S MAIDEN NAME <b>Nancy Bennett</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Violet Cooper. Ellerslie, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>4-6 yds</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Urinary system Failure</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>March</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Mar 1</b> , 19 <b>59</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William R. James</b> M.D. <b>Wm. R. James St</b> <b>3-5-59</b> PHYSICIAN'S NAME (Type) <b>William R. James</b> <b>Hyndman, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 6, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hyndman, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Leeper</b>		ADDRESS <b>Hyndman, Pa.</b>	24a. REC'D BY REGISTRAR DATE <b>MAR 10 59</b>
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

2222

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>PLACE OF BIRTH <i>John Doe, Md.</i></p>		<p>DATE OF BIRTH <i>Jan 15 1882</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>PLACE OF DEATH <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF PHYSICIAN <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF FUNERAL HOME <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF BURIAL PLACE <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF CEMETERY <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF INTERVIEWER <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF WITNESS <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF CORONER <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF JURY <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF JUDGE <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF CLERK <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF SHERIFF <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF DEPUTY SHERIFF <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF CONSTABLE <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF JURY <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF JUDGE <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF CLERK <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF SHERIFF <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF DEPUTY SHERIFF <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	
<p>NAME OF CONSTABLE <i>John Doe, Md.</i></p>		<p>DATE OF DEATH <i>Jan 15 1927</i></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2509

## CERTIFICATE OF DEATH

02501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>38 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>50 WEAPE DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>BERKENBAUGH</u> Last <u>BERKENBAUGH</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>19 59</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 26, 1977</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>02</u> Days <u>02</u> Hours <u>02</u> Min. <u>02</u>		IF UNDER 24 HRS. Months <u>02</u> Days <u>02</u> Hours <u>02</u> Min. <u>02</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MxPekin, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES BEREANY (DECEASED)</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE Kane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>PATIENTS CHART</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thaemia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Right Cerebral Haemorrhage</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>5 wks</u> <u>7 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 17, 1959</u> , to <u>Mar 26, 1959</u> , that I last saw the deceased alive on <u>Mar. 25, 1959</u> , and that death occurred at <u>12:25A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clay E. Durrett</u>				ADDRESS (Street, city or town, state) <u>236 Va. Ave. Cumberland, Md.</u>			
DATE SIGNED <u>3/26/59</u>							
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett</u>				M.D. <u>236 Va. Avenue, Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Catholic Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				ADDRESS <u>John J. Hafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>							

103301

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

0000

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

LOCATION: \_\_\_\_\_

Other fields include: SEX, AGE, OCCUPATION, and various checkboxes for medical history and circumstances of death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02502

Reg. Dist. No.

2510

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>			d. STREET ADDRESS <u>BOWMANS ADDITION</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>D.</u> Last <u>BONNER</u>			4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1911</u>		9. AGE (in years last birthday) <u>47 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carmans Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>WILBERT BONNER</u>		
14. MOTHER'S MAIDEN NAME <u>ARBELLA SMITH</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>220 10 1212</u>			17. INFORMANT <u>MAE BONNER, BOWMANS ADDITION, CUMB. MD.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>3/2/1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Mar. 4, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>		ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Place of Death: \_\_\_\_\_

10. Cause of Death: \_\_\_\_\_

11. Manner of Death: \_\_\_\_\_

12. Signature of Medical Examiner: \_\_\_\_\_

13. Title of Medical Examiner: \_\_\_\_\_

14. Date of Certificate: \_\_\_\_\_

15. State of Maryland: \_\_\_\_\_

05503

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2587

## CERTIFICATE OF DEATH

02503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Gills Hill</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John R. Bradley</b>				4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 22, 1893</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Celenease Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Bradley</b>				14. MOTHER'S MAIDEN NAME <b>Martha Metz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>1st W.W. 217-03-2157</b>		17. INFORMANT <b>Mrs. John Bradley</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1957</b> 19 to <b>March 31, 1959</b> , that I last saw the deceased alive on <b>Feb 28</b> , 1959, and that death occurred at <b>9 a. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b>				ADDRESS (Street, city or town, state)		DATE SIGNED <b>3-31-59</b>	
PHYSICIAN'S NAME (Type) <b>Leslie R. Miles, M.D. Lonaconing, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Catharine S. House</b>			

05508

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

1937

Reg. No. 114

Name of Deceased George Johnson		Sex Male		Age 65		Date of Birth May 28, 1872		Place of Birth Maryland		Race White		Religion Roman Catholic		Marital Status Married		Occupation Farmer		Cause of Death Heart Disease		Date of Death June 1, 1937		Place of Death Home		Time of Death 10:30 AM		Signature of Physician J. H. Smith		Signature of Registrar J. H. Smith		Signature of Coroner J. H. Smith		Signature of Medical Examiner J. H. Smith		Signature of Burial Officer J. H. Smith		Signature of Undertaker J. H. Smith		Signature of Funeral Home J. H. Smith		Signature of Cemetery J. H. Smith		Signature of Burial Place J. H. Smith		Signature of Interment J. H. Smith		Signature of Burial Officer J. H. Smith		Signature of Undertaker J. H. Smith		Signature of Funeral Home J. H. Smith		Signature of Cemetery J. H. Smith		Signature of Burial Place J. H. Smith		Signature of Interment J. H. Smith	
Name of Deceased George Johnson		Sex Male		Age 65		Date of Birth May 28, 1872		Place of Birth Maryland		Race White		Religion Roman Catholic		Marital Status Married		Occupation Farmer		Cause of Death Heart Disease		Date of Death June 1, 1937		Place of Death Home		Time of Death 10:30 AM		Signature of Physician J. H. Smith		Signature of Registrar J. H. Smith		Signature of Coroner J. H. Smith		Signature of Medical Examiner J. H. Smith		Signature of Burial Officer J. H. Smith		Signature of Undertaker J. H. Smith		Signature of Funeral Home J. H. Smith		Signature of Cemetery J. H. Smith		Signature of Burial Place J. H. Smith		Signature of Interment J. H. Smith													
Name of Deceased George Johnson		Sex Male		Age 65		Date of Birth May 28, 1872		Place of Birth Maryland		Race White		Religion Roman Catholic		Marital Status Married		Occupation Farmer		Cause of Death Heart Disease		Date of Death June 1, 1937		Place of Death Home		Time of Death 10:30 AM		Signature of Physician J. H. Smith		Signature of Registrar J. H. Smith		Signature of Coroner J. H. Smith		Signature of Medical Examiner J. H. Smith		Signature of Burial Officer J. H. Smith		Signature of Undertaker J. H. Smith		Signature of Funeral Home J. H. Smith		Signature of Cemetery J. H. Smith		Signature of Burial Place J. H. Smith		Signature of Interment J. H. Smith													



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2571 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	c. LENGTH OF STAY IN 1b <b>Lifetime</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>266 E. Main Street</b>		d. STREET ADDRESS <b>266 E. Main Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Katherine</b> First <b>Brady</b> Middle <b>Brady</b> Last <b>Brady</b>	4. DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>1959</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-15-1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Eckhart, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Patrick Brady</b>		14. MOTHER'S MAIDEN NAME <b>Honora Kenny</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Joseph Spates, 270 E. Main,</b>		Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Sudden</b> (c) <b>420.1</b> DUE TO cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. McLane</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. McLane M.D. asst</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-30-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bulah H. Montevale</b>		24a. REC'D BY REGISTRAR DATE <b>APR 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoms</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

2572

02508

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Moontsavage</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Bridges</u> Middle <u>Bridges</u> Last <u>Bridges</u>				4. DATE OF DEATH <u>Mar 13</u> Month <u>Mar</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 12 1959</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Mount Savage Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Donald Bridges</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Beeman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Theresa Bridges</u>		17. INFORMANT <u>Theresa Bridges</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity 7 lb 10 oz</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>19 hrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 12</u> 19 <u>59</u> , to <u>Mar 13</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 13</u> 19 <u>59</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>Mar 14 1959</u> ACTUAL SIGNATURE <u>WOM Lane</u> M.D. <u>—</u> PHYSICIAN'S NAME (Type) <u>WOM Lane MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u> ADDRESS <u>23 E. Main, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAR 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1000173XVI



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02506

CERTIFICATE OF DEATH

Reg. Dist. No.

2511

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>50 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>61 Greene St.</u>				d. STREET ADDRESS <u>61 Greene St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES ALVIN BRILL</u>				4. DATE OF DEATH <u>March 5, 1959</u> 19 <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25, 1881</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Kirby, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Brill</u>				14. MOTHER'S MAIDEN NAME <u>Marian Saville</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 05 5894</u>		17. INFORMANT <u>Arthur Brill</u> Address <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 1/2 hrs</u> <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lead heart by computed (mod thx) duct arteriosclerotic pyrene</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-3-</u> , 19 <u>59</u> , to <u>3-5-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-4-</u> , 19 <u>59</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>576 ...</u> DATE SIGNED <u>3-6-59</u> ACTUAL SIGNATURE <u>R. Brill</u> M.D. <u>576 ...</u> PHYSICIAN'S NAME (Type) <u>Cumberland Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			



CERTIFICATE OF DEATH

1951

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. DATE OF DEATH April 4, 1968		6. PLACE OF DEATH Memphis, Tennessee	
7. DATE OF BIRTH January 5, 1933		8. PLACE OF BIRTH Jackson, Mississippi		9. OCCUPATION Attorney		10. MARITAL STATUS Single		11. EDUCATION High School Graduate		12. RELIGION Methodist	
13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. ICD-9 CODE 410.9		16. DRUGS None		17. ALCOHOL None		18. TOBACCO None	
19. SIGNATURE OF PHYSICIAN [Signature]		20. SIGNATURE OF REGISTRAR [Signature]		21. SIGNATURE OF WITNESS [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF WITNESS [Signature]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02507

Reg. Dist. No.

2512

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>10 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		e. STREET ADDRESS <b>507 Oldtown Road</b>	
3. NAME OF DECEASED (Type or print) <b>NORA E. BRINKER</b>		4. DATE OF DEATH <b>MARCH 22 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>James Boxell</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Farrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Kenneth Roby, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema and Congestion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis</b> (a), stating the underlying cause lost. (c) <b>Arteriosclerotic Cardiovascular disease, generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 Wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of Left Hip</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:00 a.m. 12/30 1958</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Cumberland, Alleg. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-35-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 24 59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiser</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>2 Weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W.</b> Last <b>Broadwater</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17th</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27th, 1876</b>
9. AGE (In years lost birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.-Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.P.A.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Broadwater</b>		14. MOTHER'S MAIDEN NAME <b>Mary Custer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>213-18-2704</b>	
17. INFORMANT <b>Mrs. Harry Haberlein, Eckhart, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>Chronic Atherosclerotic Cardiovascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>20 yrs?</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b> (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/12/59</b> , 19, to <b>3/17/59</b> , 19, that I last saw the deceased alive on <b>3/17/59</b> , 19, and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 Broadway, Frostburg, Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Martin M. Rothstein, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Martin M. Rothstein, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Robison Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Garrett County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>1 Wk.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ollie</b>		4. DATE OF DEATH Month <b>3</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-1907</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>51</b> Days <b>19</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>51</b> Days <b>19</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Robertson</b>		14. MOTHER'S MAIDEN NAME <b>Ada Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William Cecil, Midlothian, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>331X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Influenza</b>		INTERVAL BETWEEN ONSET AND DEATH <b>50 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/12/59</b> , 19 <b>59</b> , to <b>3/19/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/19/59</b> , 19 <b>59</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>48 BROADWAY</b> DATE SIGNED	
ACTUAL SIGNATURE <b>Martin M. Rothstein M.D.</b>		PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN M.D. FROSTBURG - MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montecant</b>		24a. REC'D BY REGISTRAR <b>MAR 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Bana</b>		25. ADDRESS <b>23 E. Main, Frostburg, Md.</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-100

2014

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Time of death: [illegible]  
8. Cause of death: [illegible]  
9. Place of death: [illegible]  
10. Signature of physician: [illegible]  
11. Signature of registrar: [illegible]  
12. Date of filing: [illegible]

LAUREL BOMD

Handwritten signature



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2513

## CERTIFICATE OF DEATH

Reg. Dist. No.

02510

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>M.</u> Last <u>CHISHOLM</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1885</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN RIEHL</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA RUMPT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-16-4681A</u>	
17. INFORMANT <u>John F. Chisholm</u>		Address <u>Cumberland, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anteroseptal myocardial Infarction, recent, with</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease with cardiomegaly</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Genitourinary tract infection</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>February 15, 1959</u> , to <u>March 3rd, 1959</u> , that I last saw the deceased alive on <u>March 3rd, 1959</u> , and that death occurred at <u>5:25 p.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Algonquin Hotel, Cumberland, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Wyand F. Doerner, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>
22d. LOCATION (City, town, or county) <u>Cumberland Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>		ADDRESS <u>Cumberland Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02511

2514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 HOURS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>Peter</b> Last <b>CODIRE</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 20, 1920</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>PETER M. CODIRE (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>REGINA MCHUGH CODIRE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>PATIENTS CHART</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>meningitis</b> <b>340.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3-29</b> , 19 <b>59</b> , to <b>3-30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-29</b> , 19 <b>59</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 GREENE ST., CUMBERLAND, MD.</b> DATE SIGNED <b>3-30-59</b> ACTUAL SIGNATURE <b>L Brings</b> M.D. <b>57 Greene St.,</b> PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, M.D.</b> <b>57 GREENE ST., CUMBERLAND, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4-2-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

MEDICAL CERTIFICATION

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02512

2515

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>114 Winton Place</b>		d. STREET ADDRESS <b>1 114 Winton Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harriet</b> Middle <b>Elizabeth</b> Last <b>Cooper</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1878</b>
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Harman, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob C. Harper</b>		14. MOTHER'S MAIDEN NAME <b>Susan McDonald</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Walter M. Fuller</b>		Address <b>Cumberland, 420 Beall St., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic heart disease</b> DUE TO (c) <b>generalized atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b> <b>1 year</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-4</b> , 19 <b>57</b> , to <b>3-5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-5</b> , 19 <b>59</b> , and that death occurred at <b>4:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Greene St.,</b> DATE SIGNED ACTUAL SIGNATURE <b>L. Brings</b> M.D. PHYSICIAN'S NAME (Type) <b>Lewis Brings M.D.</b> <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Harper Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Harman, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2516

CERTIFICATE OF DEATH

02513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
c. LENGTH OF STAY IN 1b <b>14 DAYS</b>				d. STREET ADDRESS <b>1 633 MARYLAND AVENUE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>PEARL</b> Last <b>CORNWELL</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 8, 1893</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>IRA THOMAS HITE</b>			
14. MOTHER'S MAIDEN NAME <b>EMMA FADLEY</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary Artery Disease</b> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>2/20/57</b> 19____, to <b>2/7/57</b> 19____, that I last saw the deceased alive on <b>3/7/57</b> 19____, and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.			
21. ADDRESS (Street, city or town, state)				21. DATE SIGNED <b>3/10/57</b>			
ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>Cumberland Md</b>				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park Cumberland Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				24. REC'D BY REGISTRAR <b>MAR 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Christina S. Kline</b>	

CERTIFICATE OF DEATH

1955

10018

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: [Illegible]

DATE: [Illegible]

CAUSE OF DEATH: [Illegible]

LOCATION: [Illegible]

Other fields include: SEX, AGE, OCCUPATION, and SIGNATURE.

Vertical text on the right margin, likely a filing or processing stamp.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02514

Reg. Dist. No.

2575

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>Cuthbertson</b> Middle <b>Watercliffe</b> Last		4. DATE OF DEATH <b>March</b> 19 19 59	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1900</b> 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Celanese Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp</b>	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Cuthbertson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Park</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-10-2356</b>	
17. INFORMANT <b>Mrs. William Cuthbertson</b> Address <b>Lonaconing, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> 292.3 DUE TO <b>Recurrent Phlebitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Agonogenic Myeloid Metaplasia</b> (c) <b>Wife</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 years</b> <b>7 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>56</b> to <b>March</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>March 19, 1959</b> , and that death occurred at <b>9 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>LONA CONING MD</b> DATE SIGNED <b>3-20-59</b>			
ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>LESLIE R. MILLER JR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/22/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 23 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 and be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 240 3-20-59 at

## CERTIFICATE OF DEATH

2517

Items 8, 9 Film 240 4-6-59 at

Reg. Dist. No.

02515

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>119 Bedford ST.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>119 Bedford ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Louis</u> Last <u>Dauids</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1889</u> <u>Oct. 26</u> <u>1889</u> (In years last birthday) yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Eng. in Ordnance Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Dauids</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Kehr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-32-877</u>	
17. INFORMANT <u>Elva M. Dauids</u>		Address <u>119 Bedford St. Cumberland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 5, 1959</u> to <u>Mar. 11, 1959</u> , that I last saw the deceased alive on <u>Mar. 10, 1959</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clayton J. Summitt</u> M.D. <u>23674 Car Cumberland</u>		DATE SIGNED <u>3/13/59</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 13, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc. Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 16 '59</u>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2517

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1881		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915		9. PLACE OF MARRIAGE Baltimore, Md.		10. NAME OF SPOUSE Mary E. Harris	
11. DATE OF DEATH 1946		12. TIME OF DEATH 10:30 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN J. H. Harris		17. SIGNATURE OF WITNESS J. H. Harris		18. SIGNATURE OF DECEASED J. H. Harris		19. SIGNATURE OF SPOUSE Mary E. Harris		20. SIGNATURE OF CLERK J. H. Harris	
21. NAME OF HOSPITAL None		22. NAME OF PHYSICIAN J. H. Harris		23. NAME OF NURSE None		24. NAME OF CLERK J. H. Harris		25. NAME OF SPOUSE Mary E. Harris	
26. NAME OF DECEASED JAMES H. HARRIS		27. SEX Male		28. AGE 65		29. DATE OF BIRTH 1881		30. PLACE OF BIRTH Baltimore, Md.	
31. OCCUPATION Carpenter		32. MARITAL STATUS Married		33. DATE OF MARRIAGE 1915		34. PLACE OF MARRIAGE Baltimore, Md.		35. NAME OF SPOUSE Mary E. Harris	
36. DATE OF DEATH 1946		37. TIME OF DEATH 10:30 AM		38. PLACE OF DEATH Home		39. CAUSE OF DEATH Heart Disease		40. MANNER OF DEATH Natural	
41. SIGNATURE OF PHYSICIAN J. H. Harris		42. SIGNATURE OF WITNESS J. H. Harris		43. SIGNATURE OF DECEASED J. H. Harris		44. SIGNATURE OF SPOUSE Mary E. Harris		45. SIGNATURE OF CLERK J. H. Harris	
46. NAME OF HOSPITAL None		47. NAME OF PHYSICIAN J. H. Harris		48. NAME OF NURSE None		49. NAME OF CLERK J. H. Harris		50. NAME OF SPOUSE Mary E. Harris	



2576

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>10 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X R.D. 3, Frostburg, Box 61</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Mary</b> Middle <b>C.</b> Last <b>Delaney</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18th</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4th, 1891</b>		9. AGE (In years lost birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Housework</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Reilly</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Malloy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-01-3657A</b>		INFORMANT Address <b>John A. Delaney, RD 3, F'bg., Md. Box 61</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma Descending Colon</b> 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/8</b> , 19 <b>59</b> , to <b>March 18, 19 59</b> at I last saw the deceased alive on <b>March 18</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Hilda Jane Walters, M.D. 48 Broadway, Frostburg, Md. 3/20/59</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Hilda Jane Walters, M.D. " " "</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-21-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 23 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02517

Reg. Dist. No.

2518

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY IN 1b <u>24 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>62 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1456 Williams St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSE EARL DeVORE</u>		4. DATE OF DEATH Month Day Year <u>March 16 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Signalman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John DeVore</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Witt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705 05 1809</u>	
17. INFORMANT <u>Mrs. Sarah DeVore</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C-V Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left hip</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell At Home</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:15 p.m. 3/8/59 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Cumberland, Alleg. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hilcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

FOR STATE  
HEALTH OFF

DATE OF DEATH  
(month, day, year)

TIME (hour, minute)

DATE  
(month, day, year)

TIME (hour, minute)

PLACE OF DEATH

CAUSE OF DEATH (fill in with words and figures)

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

OTHER CAUSE

OTHER CAUSE

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G240 3-30-59 et

## CERTIFICATE OF DEATH

02518

Reg. Dist. No.

2519

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pinto Md Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital-D.O.A.</b> <b>Allegany Ballistics</b>				d. STREET ADDRESS <b>407 Linden Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Reese Irvin Diehl</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1908</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone installer- Cumberland, Md</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank I. Diehl</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Mae Robertson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-0785</b>		17. INFORMANT <b>Mrs. Marie Diehl 407 Linden, St. Cumberland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Unusual death</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Nat while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <b>June 24, 1957</b> to <b>3-18-59</b> , that I last saw the deceased alive on <b>3-14-59</b> , and that death occurred at <b>10 a M.</b> from the causes and on the date stated above. <b>Wm. A. Williams M.D. Cumberland Md 3/18/59</b> ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>			ADDRESS <b>Cumberland Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Christina S. Knaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



## 02519

2577

MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

02319

MARYLAND STATE DEPARTMENT OF HEALTH AND WELFARE

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF REGISTRAR	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF BURIAL PLACE		15. SIGNATURE OF INTERVIEWER	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF PROSECUTOR		20. SIGNATURE OF DEFENSE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JUDGE		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
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1. NAME OF DECEASED

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3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL PLACE

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF PROSECUTOR

20. SIGNATURE OF DEFENSE

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02520

Reg. Dist. No.

2520

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN lb <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>117 Independence St.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u> d. STREET ADDRESS <u>117 Independence St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHARLES M EIRICH</u>				<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>27</u> Year <u>19 59</u>													
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 26, 1909</u>		<b>9. AGE</b> (In years last birthday) <u>49</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bakery</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>Charles L. Eirich</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Crutchley</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214 05 9296</u>		<b>17. INFORMANT</b> Address <u>Mrs. Inez Eirich Cumberland, Md.</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion, right</u> DUE TO (c) <u>Coronary Sclerosis, right</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>3-4 days</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary embolism from mural thrombus</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <u>Benedict Skitarelis</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b>													
<b>EXAMINER'S NAME (Type)</b> <u>Benedict Skitarelis, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>													
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>March 27, 1959</u>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/30/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Asbury Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Moorefield, W/ Va.</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Byron Kight</u>				<b>ADDRESS</b> <u>Cumberland, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>MAR 31 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Kraus</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
DEPT. OF HEALTH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		FINDINGS		OPINION		SIGNATURE	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER		TITLE OF EXAMINER		OFFICE OF EXAMINER	
DATE OF REPORT		TIME OF REPORT		PLACE OF REPORT		NAME OF REPORTER		TITLE OF REPORTER		OFFICE OF REPORTER	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G240, 3/23/59, 100

02521

## CERTIFICATE OF DEATH

Reg. Dist. No.

2578

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
c. LENGTH OF STAY IN 1b <b>Lifetime</b>		d. STREET ADDRESS <b>125 E. Main</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>125 East Main</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nellie V. Fisher</b>		4. DATE OF DEATH Month Day Year <b>3 14 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-10-1874</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Eckhart, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John A. McMullen</b>		14. MOTHER'S MAIDEN NAME <b>Mary V. Jordan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Jackson Fisher, Consolidation Village</b>		Address <b>Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac dilatation</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr- myocardial insufficiency</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>8-9 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>50</b> , to <b>3-14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-4</b> , 19 <b>59</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>39 W. MAIN ST., FROSTBURG, Md.</b> DATE SIGNED <b>3/17/59</b>			
ACTUAL SIGNATURE <b>H.C. Diehl</b>		M.D. <b>H.C. Diehl, M.D.</b>	
PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>		ADDRESS <b>FROSTBURG, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 19 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Montross</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

7-11-14



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02522

Reg. Dist. No.

2521

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Viola M. Fogtman</u>		4. DATE OF DEATH <u>March 16th 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 23,</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months <u>64</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Spoerl</u>		14. MOTHER'S MAIDEN NAME <u>Clara Connors</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Pt's chart- Husband</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Occlusion, Right Coronary Artery</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive and Arteriosclerotic Heart disease, with cardiomegaly &amp; old massive anterior myocardial infarction</u> (c) <u>13 months</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Obstruction of Sigmoid Colon, due chronic diverticulitis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 25, 58</u> to <u>March 16th 1959</u> , that I last saw the deceased alive on <u>March 16th 1959</u> , and that death occurred at <u>9:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wyand F. Doerner, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Algonquin Hotel,</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>		<u>Cumberland, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 19, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter + Paul Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb MD</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 20 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 10

10-2288

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. PLACE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>		<p>15. SIGNATURE OF PHYSICIAN</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. DATE OF DEATH</p>		<p>18. TIME OF DEATH</p>		<p>19. SIGNATURE OF PHYSICIAN</p>		<p>20. SIGNATURE OF REGISTRAR</p>	
<p>21. DATE OF DEATH</p>		<p>22. TIME OF DEATH</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF REGISTRAR</p>	
<p>25. DATE OF DEATH</p>		<p>26. TIME OF DEATH</p>		<p>27. SIGNATURE OF PHYSICIAN</p>		<p>28. SIGNATURE OF REGISTRAR</p>	
<p>29. DATE OF DEATH</p>		<p>30. TIME OF DEATH</p>		<p>31. SIGNATURE OF PHYSICIAN</p>		<p>32. SIGNATURE OF REGISTRAR</p>	
<p>33. DATE OF DEATH</p>		<p>34. TIME OF DEATH</p>		<p>35. SIGNATURE OF PHYSICIAN</p>		<p>36. SIGNATURE OF REGISTRAR</p>	
<p>37. DATE OF DEATH</p>		<p>38. TIME OF DEATH</p>		<p>39. SIGNATURE OF PHYSICIAN</p>		<p>40. SIGNATURE OF REGISTRAR</p>	
<p>41. DATE OF DEATH</p>		<p>42. TIME OF DEATH</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF REGISTRAR</p>	
<p>45. DATE OF DEATH</p>		<p>46. TIME OF DEATH</p>		<p>47. SIGNATURE OF PHYSICIAN</p>		<p>48. SIGNATURE OF REGISTRAR</p>	
<p>49. DATE OF DEATH</p>		<p>50. TIME OF DEATH</p>		<p>51. SIGNATURE OF PHYSICIAN</p>		<p>52. SIGNATURE OF REGISTRAR</p>	
<p>53. DATE OF DEATH</p>		<p>54. TIME OF DEATH</p>		<p>55. SIGNATURE OF PHYSICIAN</p>		<p>56. SIGNATURE OF REGISTRAR</p>	
<p>57. DATE OF DEATH</p>		<p>58. TIME OF DEATH</p>		<p>59. SIGNATURE OF PHYSICIAN</p>		<p>60. SIGNATURE OF REGISTRAR</p>	
<p>61. DATE OF DEATH</p>		<p>62. TIME OF DEATH</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF REGISTRAR</p>	
<p>65. DATE OF DEATH</p>		<p>66. TIME OF DEATH</p>		<p>67. SIGNATURE OF PHYSICIAN</p>		<p>68. SIGNATURE OF REGISTRAR</p>	
<p>69. DATE OF DEATH</p>		<p>70. TIME OF DEATH</p>		<p>71. SIGNATURE OF PHYSICIAN</p>		<p>72. SIGNATURE OF REGISTRAR</p>	
<p>73. DATE OF DEATH</p>		<p>74. TIME OF DEATH</p>		<p>75. SIGNATURE OF PHYSICIAN</p>		<p>76. SIGNATURE OF REGISTRAR</p>	
<p>77. DATE OF DEATH</p>		<p>78. TIME OF DEATH</p>		<p>79. SIGNATURE OF PHYSICIAN</p>		<p>80. SIGNATURE OF REGISTRAR</p>	
<p>81. DATE OF DEATH</p>		<p>82. TIME OF DEATH</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF REGISTRAR</p>	
<p>85. DATE OF DEATH</p>		<p>86. TIME OF DEATH</p>		<p>87. SIGNATURE OF PHYSICIAN</p>		<p>88. SIGNATURE OF REGISTRAR</p>	
<p>89. DATE OF DEATH</p>		<p>90. TIME OF DEATH</p>		<p>91. SIGNATURE OF PHYSICIAN</p>		<p>92. SIGNATURE OF REGISTRAR</p>	
<p>93. DATE OF DEATH</p>		<p>94. TIME OF DEATH</p>		<p>95. SIGNATURE OF PHYSICIAN</p>		<p>96. SIGNATURE OF REGISTRAR</p>	
<p>97. DATE OF DEATH</p>		<p>98. TIME OF DEATH</p>		<p>99. SIGNATURE OF PHYSICIAN</p>		<p>100. SIGNATURE OF REGISTRAR</p>	

2522

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL AND WARWICK AVENUES</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDNA M FOOTE</b>		4. DATE OF DEATH Month Day Year <b>MARCH 2 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 28' 1897</b>
9. AGE (In years last birthday) yrs. <b>61</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>	
11. BIRTHPLACE (State or foreign country) <b>WESTERNPORT, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY DAYTON</b>		14. MOTHER'S MAIDEN NAME <b>EMMA DAWSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL</b>	
17. INFORMANT <b>CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, hepatic coma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Portal Cirrhosis of liver</b> DUE TO (c) <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post hemorrhagic anemia due to ruptured esophageal varices</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1, 19 59</b> to <b>March 2, 19 59</b> , that I last saw the deceased alive on <b>March 2, 19 59</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel M. Jacobson, M.D.</b>		ADDRESS (Street, city or town, state) <b>50 Pershing St., 2/4/59</b>	
PHYSICIAN'S NAME (Type) <b>Samuel M. Jacobson, M.D.</b>		DATE SIGNED <b>2/4/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 9 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/10

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2523

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
c. LENGTH OF STAY IN 1b <b>7 years</b>		d. STREET ADDRESS <b>Hillcrest Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hillcrest Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALICE</b> <b>GERTRUDE</b> <b>GOODWIN</b>		4. DATE OF DEATH <b>March 15</b> <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 23, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Finzel, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Finzel (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Sarah McKenzie (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Arthur Hawkins</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cordic Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsons Syndrome</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 years</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 March</b> , 19 <b>59</b> , to <b>15 March</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>15 March</b> , 19 <b>59</b> , and that death occurred at <b>5:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>122 South Center St. Cumberland, Md.</b> DATE SIGNED <b>3/17/59</b>			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D.		PHYSICIAN'S NAME (Type) <b>Alfred Van Ormer M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 19 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

DATE OF DEATH

DEATH

PLACE OF DEATH

AGE

SEX

DOB

POB

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

CONTRIBUTING CAUSE

MODE OF DEATH

PERMANENTLY DISABLED

RECOVERED

RECOVERED WITH RESIDUALS

RECOVERED WITH NO RESIDUALS

RECOVERED WITH RESIDUALS

RECOVERED WITH NO RESIDUALS

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02525

## 2524 CERTIFICATE OF DEATH

Reg. Dist. No.

Allegany

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>66 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Westernport</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha A. Griffin</u>		4. DATE OF DEATH Month Day Year <u>March 2, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28, - 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hammers</u>		14. MOTHER'S MAIDEN NAME <u>Chart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of larynx</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-4</u> , 19 <u>59</u> , to <u>3-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-2</u> , 19 <u>59</u> , and that death occurred at <u>4</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis Brings</u>		ADDRESS (Street, city or town, state) <u>57 Green St. Cumberland Md.</u>	
PHYSICIAN'S NAME (Type) <u>LEWIS BRINGS</u>		DATE SIGNED <u>3-3-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. Fudlock</u>		ADDRESS <u>Piedmont, W. Va.</u>	
24a. REC'D BY REGISTRAR <u>MAR 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

2525

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>20 minutes</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b> d. STREET ADDRESS <b>310 PIEDMONT AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTER L.</b> Middle <b>HARDMAN</b> Last 4. DATE OF DEATH Month <b>MARCH</b> Day <b>13</b> Year <b>19 59</b>		5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>12-17-99</b> 9. AGE (In years last birthday) <b>59</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stockman</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Merchants Wholesale</b> 11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA, Bedford County</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CLINTON HARDMAN (Deceased)</b> 14. MOTHER'S MAIDEN NAME <b>BESSIE HARDMAN (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>214-05-6260</b> 17. INFORMANT <b>CHART</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Auto coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>coronary sclerosis</b> DUE TO (c) <b>generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-1-1958</b> , to <b>3-13-1959</b> , that I last saw the deceased alive on <b>3-13-1959</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Greene Street Cumberland, Md.</b> DATE SIGNED <b>3/16/59</b> ACTUAL SIGNATURE <b>L. Brings</b> PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, M.D.</b> 57 GREEN STREET CUMBERLAND, Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>3/16/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Prk</b> 22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b> ADDRESS 24a. REC'D BY REGISTRAR <b>MAR 19 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AMERICAN  
FORD

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery	
16. Signature of church		17. Signature of family		18. Signature of neighbors	
19. Signature of friends		20. Signature of community		21. Signature of society	
22. Signature of association		23. Signature of organization		24. Signature of institution	
25. Signature of hospital		26. Signature of clinic		27. Signature of laboratory	
28. Signature of pharmacy		29. Signature of dispensary		30. Signature of office	
31. Signature of store		32. Signature of business		33. Signature of profession	
34. Signature of occupation		35. Signature of industry		36. Signature of service	
37. Signature of public		38. Signature of private		39. Signature of individual	
40. Signature of group		41. Signature of organization		42. Signature of institution	
43. Signature of hospital		44. Signature of clinic		45. Signature of laboratory	
46. Signature of pharmacy		47. Signature of dispensary		48. Signature of office	
49. Signature of store		50. Signature of business		51. Signature of profession	
52. Signature of occupation		53. Signature of industry		54. Signature of service	
55. Signature of public		56. Signature of private		57. Signature of individual	
58. Signature of group		59. Signature of organization		60. Signature of institution	
61. Signature of hospital		62. Signature of clinic		63. Signature of laboratory	
64. Signature of pharmacy		65. Signature of dispensary		66. Signature of office	
67. Signature of store		68. Signature of business		69. Signature of profession	
70. Signature of occupation		71. Signature of industry		72. Signature of service	
73. Signature of public		74. Signature of private		75. Signature of individual	
76. Signature of group		77. Signature of organization		78. Signature of institution	
79. Signature of hospital		80. Signature of clinic		81. Signature of laboratory	
82. Signature of pharmacy		83. Signature of dispensary		84. Signature of office	
85. Signature of store		86. Signature of business		87. Signature of profession	
88. Signature of occupation		89. Signature of industry		90. Signature of service	
91. Signature of public		92. Signature of private		93. Signature of individual	
94. Signature of group		95. Signature of organization		96. Signature of institution	
97. Signature of hospital		98. Signature of clinic		99. Signature of laboratory	
100. Signature of pharmacy		101. Signature of dispensary		102. Signature of office	

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2526

Item 9 Film G240 3-24-59 et

2526

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02527

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>L DAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>1823 LAFAYETTE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>W</b> Last <b>HARE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1884</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Park Police</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Cumberland</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>Martinsburg U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS HARE</b>		14. MOTHER'S MAIDEN NAME <b>NANCY DYCKE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-9234</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thaemia</b> <b>194X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Thyroid</b> DUE TO (c) <b>Secondary Anaemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>4 yrs</b> <b>4 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 10, 19 59</b> to <b>Mar 15, 19 59</b> , that I last saw the deceased alive on <b>3/15, 19 59</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clayton L. Linnett</b>		ADDRESS (Street, city or town, state) <b>236 W. Lee Cumberland</b> DATE SIGNED <b>3/18/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Points, W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hare</b>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2527

## CERTIFICATE OF DEATH

02528  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>38 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MR. Newton B. HEIMS</b>		4. DATE OF DEATH Month Day Year <b>MARCH 1 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/80</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES Heims</b>		14. MOTHER'S MAIDEN NAME <b>CLARA Leedy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease with cardiomegaly, several yrs</b> <b>420.0</b> DUE TO <b>old myocardial infarct, congestive failure and</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial degeneration</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pyelonephritis with early uremia; Occlusion, rt. popliteal art.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1958</b> to <b>March 1, 1959</b> , that I last saw the deceased alive on <b>March 1st, 1959</b> , and that death occurred at <b>12:10 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Algonquin Hotel</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Wyand R. Doerner</b> M.D.		ADDRESS (Street, city or town, state) <b>Algonquin Hotel</b>	
PHYSICIAN'S NAME (Type) <b>DR. WYAND DOERNER</b>		ADDRESS <b>ALGONQUIN HOTEL, CUMBERLAND, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/3/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Umbria Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Osceola Mills, Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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(1992)

3478 (2002)

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2579

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>3 Mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>C.</b> Last <b>Henckel</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13th</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18th, 1873</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Valentine Henckel</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Miss Edna Henckel, Mt. Savage, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 12</b> , 19 <b>58</b> , to <b>March 13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Mar 13</b> , 19 <b>59</b> , and that death occurred at <b>7:45</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. O. McLane</b>		ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b> DATE SIGNED <b>Mar 13, 1959</b>	
PHYSICIAN'S NAME (Type) <b>W. O. McLane,</b>		M.D. " " " "	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-16-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hump</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove barban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL CO. OF MD.

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Mr. Savage

Mr. A. H. H. H.

John Savage

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2528  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8/5/58</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A.</b> Last <b>Hendrickson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/10/1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md. State Roads</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM HENDRICKSON</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA HUFF</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O. Box 599</b> <b>Allegany County Infirmary Records</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Sclerosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocardial Degeneration</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe Dehydration</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/5/58</b> , 19____, to <b>3/15/59</b> , 19____, that I last saw the deceased alive on <b>3/14/59</b> , 19____, and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>3/16/59</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b> <b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/18/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 19 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1880

STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

SEX

MARRIAGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT CLERK

NAME OF DEPUTY CLERK



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02531

Reg. Dist. No.

2529

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b <b>02 Cumberland,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>407 Beall St.,</b>			d. STREET ADDRESS <b>407 Beall St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Annette</b>			4. DATE OF DEATH <b>MARCH 1, 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 13, 1879</b>		9. AGE (In years last birthday) <b>79</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Linen folder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hosp. Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Leisenring, Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>George Hensel</b>		
14. MOTHER'S MAIDEN NAME <b>Ann Prinkey</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mrs. C. F. Purdham, 5009 Hyattsville, Md. 54th Rogers Hts</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4-20.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (a), stating the underlying cause lost, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SUDDEN</b>					INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 3, 1959</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/6/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Connellsville, Penna.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

NAME OF DECEASED  
AGE

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILE CLERK

NAME OF ASSISTANT

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILE CLERK

NAME OF ASSISTANT

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILE CLERK

NAME OF ASSISTANT

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02532

Reg. Dist. No.

2530

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Maryland</b>				c. LENGTH OF STAY IN lb <b>5 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>210 Knox St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>E.</b> Last <b>Higgins</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22nd</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-1-1885</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Principal</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>							
13. FATHER'S NAME <b>James Higgins</b>				14. MOTHER'S MAIDEN NAME <b>Mary Douglas Higgins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Charles Marks</b> Address <b>Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic and coronary heart disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3 - 18</b> , 19 <b>57</b> , to <b>3 - 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3 - 22 -</b> , 19 <b>59</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Regina W. Ballin</b>				ADDRESS (Street, city or town, state) <b>62 Greene St.</b> DATE SIGNED <b>3-23-59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. R. W. Ballin</b>				<b>62 Greene St., Cumberland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/25/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2030

DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND

1. Name of deceased		2. Sex		3. Age		4. Date of birth	
5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death	
9. Signature of physician		10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of coroner		19. Signature of medical examiner		20. Signature of pathologist	
21. Signature of nurse		22. Signature of pharmacist		23. Signature of dentist		24. Signature of optician	
25. Signature of undertaker		26. Signature of funeral home		27. Signature of cemetery		28. Signature of burial place	
29. Signature of health officer		30. Signature of coroner		31. Signature of medical examiner		32. Signature of pathologist	
33. Signature of nurse		34. Signature of pharmacist		35. Signature of dentist		36. Signature of optician	
37. Signature of undertaker		38. Signature of funeral home		39. Signature of cemetery		40. Signature of burial place	
41. Signature of health officer		42. Signature of coroner		43. Signature of medical examiner		44. Signature of pathologist	
45. Signature of nurse		46. Signature of pharmacist		47. Signature of dentist		48. Signature of optician	
49. Signature of undertaker		50. Signature of funeral home		51. Signature of cemetery		52. Signature of burial place	
53. Signature of health officer		54. Signature of coroner		55. Signature of medical examiner		56. Signature of pathologist	
57. Signature of nurse		58. Signature of pharmacist		59. Signature of dentist		60. Signature of optician	
61. Signature of undertaker		62. Signature of funeral home		63. Signature of cemetery		64. Signature of burial place	
65. Signature of health officer		66. Signature of coroner		67. Signature of medical examiner		68. Signature of pathologist	
69. Signature of nurse		70. Signature of pharmacist		71. Signature of dentist		72. Signature of optician	
73. Signature of undertaker		74. Signature of funeral home		75. Signature of cemetery		76. Signature of burial place	
77. Signature of health officer		78. Signature of coroner		79. Signature of medical examiner		80. Signature of pathologist	
81. Signature of nurse		82. Signature of pharmacist		83. Signature of dentist		84. Signature of optician	
85. Signature of undertaker		86. Signature of funeral home		87. Signature of cemetery		88. Signature of burial place	
89. Signature of health officer		90. Signature of coroner		91. Signature of medical examiner		92. Signature of pathologist	
93. Signature of nurse		94. Signature of pharmacist		95. Signature of dentist		96. Signature of optician	
97. Signature of undertaker		98. Signature of funeral home		99. Signature of cemetery		100. Signature of burial place	

2588

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b>	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>S.</b> Last <b>Himmelwright</b>		4. DATE OF DEATH Month <b>March</b> Day <b>14th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5th, 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hous ewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Kimberley</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Porter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address <b>Mrs. Ruth Snyder, Eckhart, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x</b> DUE TO <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Cerebral hemorrhage</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 16, 1957</b> to <b>March 14, 1959</b> that I last saw the deceased alive on <b>Feb 21, 1959</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W O Mc Lane</b>		DATE SIGNED ADDRESS (Street, city or town, state) <b>167 E. Main St., F'bg., Md. MAR 16 1959</b>	
PHYSICIAN'S NAME (Type) <b>W. O. McLane,</b>		M.D. " " " " " " <b>1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-17-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Clayton S. Hume</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

STATE OF MARYLAND

2528

Allegheny

Maryland

Allegheny

Allegheny

Allegheny

1-2-29

March

Allegheny

Allegheny

May 10, 1909

Allegheny

UNA

Maryland

own housework

own housework

Allegheny

Allegheny

Mrs. Ruth Snyder, Allegheny, Md.

Mr. E. H. Hahn et al., Allegheny, Md.

Md.

Md.

Allegheny, Md.

Allegheny Cemetery

Allegheny

John R. Dyer, Allegheny, Md.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02534

2531

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>5/20/57</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>Rt.#1, Vale Summit</b>		3. NAME OF DECEASED (Type or print) First Middle Last <b>Crawford S. Hoblitzell</b>		4. DATE OF DEATH Month Day Year <b>March 22, 19 59</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/22/1874</b>		9. AGE (In years last birthday) yrs. <b>84</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Coal Mining &amp; Store Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frostburg, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William S. Hoblitzell</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret P. Shearer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>P.O.Box 599, Allegany County Infirmary Records</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocardial Degeneration</b> (c) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from <b>5/20/57</b> , 19 <b>59</b> , to <b>3/22/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/21/59</b> , 19 <b>59</b> , and that death occurred at <b>12:10 P.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>49 Greene St.</b>	
ACTUAL SIGNATURE <b>James E. McLean</b>		M.D. <b>3/23/59</b>		DATE SIGNED		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-24-59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Maryland</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Frostburg, Md.</b>		22e. (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst</b>		ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Joseph A. Smith		Male		35	
Date of Death		Place of Death		Cause of Death	
3/25/22		St. James's, Kansas		Pneumonia	
Time of Death		Occupation		Residence	
12:10 PM		Farmer		St. James's, Kansas	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Name of Physician		Name of Registrar		Name of Coroner	
Dr. James A. Nelson		Joseph A. Smith		St. James's, Kansas	
Address of Physician		Address of Registrar		Address of Coroner	
St. James's, Kansas		St. James's, Kansas		St. James's, Kansas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2532

## CERTIFICATE OF DEATH

Reg. Dist. No.

02535

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>119 Polk St.,</b>		d. STREET ADDRESS <b>119 Polk St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bernadette</b> Middle <b>Veronica</b> Last <b>Hoenicka</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James McKenzie</b>		14. MOTHER'S MAIDEN NAME <b>Sarah McKenzie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Reid C. Hoenicka</b>		Address <b>Cumberland, Md.</b> <b>119 Polk St.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 13, 1958</b> , to <b>Mar. 13, 1959</b> , that I last saw the deceased alive on <b>Mar. 13, 1959</b> , and that death occurred at <b>9:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo H. Ley Jr.</b>		ADDRESS (Street, city or town, state) <b>456 N. Centre St.</b>	
PHYSICIAN'S NAME (Type) <b>LEO H. LEY JR.</b>		DATE SIGNED <b>3/15/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 17 '59</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

CERTIFICATE OF DEATH

AGE IN YEARS  
HIGHEST GRADE  
EDUCATION  
TAMM BOMB

NAME		TAMM BOMB	
AGE		10	
SEX		M	
RACE		W	
DATE OF BIRTH		10-10-1910	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
OCCUPATION		STUDENT	
EDUCATION		HIGH SCHOOL	
MARRIAGE		SINGLE	
RELIGION		METHODIST	
CAUSE OF DEATH		HEART DISEASE	
DATE OF DEATH		10-10-1910	
PLACE OF DEATH		BALTIMORE, MARYLAND	
SIGNATURE		[Signature]	
TITLE		[Title]	
HOSPITAL		[Hospital]	
PHYSICIAN		[Physician]	
MORSE		[Morse]	
CITY		BALTIMORE	
STATE		MARYLAND	
COUNTRY		UNITED STATES	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2533

## CERTIFICATE OF DEATH

Reg. Dist. No. 02536

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>Hanekamp</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edith</b> First Middle Last <b>Holder</b>		4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 27, 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Holder</b>		14. MOTHER'S MAIDEN NAME <b>Ann Bowden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ella Braznelle</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung, alveolar type</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sister</b> DUE TO (c) <b>6 mo?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/15</b> , 19 <b>59</b> , to <b>3/31</b> , 19 <b>59</b> that I last saw the deceased alive on <b>3/31</b> , 19 <b>59</b> , and that death occurred at <b>2</b> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>George Vach</b>			
PHYSICIAN'S NAME (Type) <b>George Vach</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John Smith		Male		45		Jan 1, 1900		New York		Jan 1, 1945		New York		Heart Disease		Natural		John Doe, M.D.		Jane Smith		Jan 1, 1945	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Date of death		24. Date of burial	
Mary Smith		Wife		123 Main St		New York		New York		10000		123-4567		Mary Smith		Jane Smith		Jan 1, 1945		Jan 1, 1945		Jan 1, 1945	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

2534

Reg. Dist. No.

02537

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>21 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES</b>						d. STREET ADDRESS <b>512 HILL STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM SCOTT</b>		First <b>WILLIAM</b>		Middle <b>SCOTT</b>		Last <b>HOLLINGSWORTH</b>		4. DATE OF DEATH Month <b>MARCH</b>		Day <b>9</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 1, 1889</b>		9. AGE (In years last birthday) <b>71</b>		10. IF UNDER 1 YEAR Months <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bell Hop</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Windsor Hotel</b>		11. BIRTHPLACE (State or foreign country) <b>MOOREFIELD, W.VA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM HOLLINGSWORTH</b>						14. MOTHER'S MAIDEN NAME <b>BERTHA WILLIS</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-16-2667</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MARYLAND</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic Jaundice - both part.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>CUMBERLAND</b>		(County) (State)	
21. I certify that I attended the deceased from <b>2-16</b> , 19 <b>59</b> , to <b>3-9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-9</b> , 19 <b>59</b> , and that death occurred at <b>10:00 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>441 N. Centre St. Cumberland, Md.</b> DATE SIGNED <b>3-10-59</b>											
ACTUAL SIGNATURE <b>William R. James</b>				M.D. <b>William R. James</b>				PHYSICIAN'S NAME (Type) <b>William R. James</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Bur. Park</b>				22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>						ADDRESS <b>CUMBERLAND, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>MAR 13 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# Item 5 Film 239 3-16-59 et 2535 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02538

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>4/6/56</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cresaptown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>			e. STREET ADDRESS <b>Along Rt. # 220</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>H.</b> Last <b>Howe</b>			4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/6/1876</b>		9. AGE (In years last birthday) <b>82</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wall Paper Bus.</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Andrew Topper</b>			14. MOTHER'S MAIDEN NAME <b>Hannah Waldron</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>705-09-3513</b>		17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Pulmonary Hypostasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> (c) <b>Cerebral Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b> <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rh. Paresis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>4/6/56</b> , 19____, to <b>3/10/59</b> , 19____, that I last saw the deceased alive on <b>3/9/59</b> , 19____, and that death occurred at <b>12:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Green Street</b> DATE SIGNED <b>3/10/59</b> ACTUAL SIGNATURE <b>James E. McLean</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b> <b>Cumberland, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>			24a. REC'D BY REGISTRAR DATE <b>MAR 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar's office to burial, cremation, or removal, and in any event within 72 hours after death.

3

152

22

1990-1991

11

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2580

## CERTIFICATE OF DEATH

Reg. Dist. No.

02539

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>3days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PHOEBE</b> Middle <b>ELLEN</b> Last <b>HUMPHREY</b>				4. DATE OF DEATH Month <b>March</b> Day <b>18th.</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 27, 1879</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Rawlings, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Sheppard</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Carter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Sarah Harris, Frostburg, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia + failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-vascular disease</b> years DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>56</b> , to <b>March</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>March 18</b> , 19 <b>59</b> , and that death occurred at <b>8 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>LONACONING 6 MD</b> DATE SIGNED <b>3-20-59</b>							
ACTUAL SIGNATURE <b>Leslie R. Miles Jr</b>				PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>3/21/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Lonaconing, MD.</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>				ADDRESS <b>LONACONING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. H.</b>							







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2536

## CERTIFICATE OF DEATH

02540

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3/10/59</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Spring Gap</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				f. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Stella</b> Middle <b>A.</b> Last <b>Irons</b>			4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1897</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Border Erison</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Husband Earl Irons, Spring Gap Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thaemia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis &amp; Decompensation</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>56</b> , to <b>March 12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>March 12</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		M.D. <b>236 Va. Ave. Cumberland</b>		ADDRESS (Street, city or town, state) <b>236 Virginia Avenue, Cumberland, Md.</b>		DATE SIGNED <b>3/14/59</b>	
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Mem. Meth. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Allegany County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				ADDRESS <b>236 Virginia Avenue, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 19 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clara S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

STATE OF NEW YORK

DEPARTMENT OF HEALTH

3235

CERTIFICATE OF DEATH

MANHATTAN STATE DEPARTMENT OF HEALTH - BATHING, 18

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

2581

Reg. Dist. No.

02541

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN TB <b>16 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>		e. STREET ADDRESS <b>302 Welsh Hill</b>	
3. NAME OF DECEASED (Type or print) <b>William A. Kear</b>		4. DATE OF DEATH Month <b>3</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mail Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Kear</b>		14. MOTHER'S MAIDEN NAME <b>Cinderella Ferry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. WM. A. Kear</b>		Address <b>Frostburg, Md.</b> <b>302 Welsh Hill.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Ascending Colon</b> <b>153.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Insufficiency</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 4</b> , 19 <b>58</b> to <b>Mar 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Mar 14</b> , 19 <b>59</b> , and that death occurred at <b>9:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>WOMcLane</b> M.D.		ADDRESS (Street, city or town, state) <b>Frostburg</b> DATE SIGNED <b>Mar 16 1959</b>	
PHYSICIAN'S NAME (Type) <b>WOMcLane MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-17-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park, Frostburg</b>	22d. LOCATION (City, town, or county) (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harfer Funeral Home</b> <b>23 E. Main, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 19 59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

freestanding (1/2 in. 5)

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2537

## CERTIFICATE OF DEATH

02542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> Winchester Rd. b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>2 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>William</u> Last <u>Kelly</u>				4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1880</u>	9. AGE (In years last birthday) yrs. <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apt. Houses</u>		11. BIRTHPLACE (State or foreign country) <u>PA. Somerset County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Annala Emerick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-10-7987</u>		17. INFORMANT Address <u>Mrs. Alberta Lease, Rt # 5 Winchester Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>apoplectic stroke</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	Month, Day, Year ____ 19 ____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>4-2</u> , 19 <u>58</u> , to <u>3-22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-22</u> , 19 <u>59</u> , and that death occurred at <u>9</u> <u>PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>576 Greenb.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Lewis Brings</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>LEWIS BRINGS MD</u> <u>Cumberland Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 25, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lybarger Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Madley, Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George,</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08742

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

0333

THE CONTINENTAL  
TAMM BOND

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of church		22. Signature of school		23. Signature of business		24. Signature of other	
25. Signature of witness		26. Signature of jury		27. Signature of court		28. Signature of state	
29. Signature of federal		30. Signature of international		31. Signature of universal		32. Signature of all	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02544

2538

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>105 Frederick Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leroy Emerson Kimes</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Druggist</u>	
11. BIRTHPLACE (State or foreign country) <u>Keyser W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Kimes</u>		14. MOTHER'S MAIDEN NAME <u>Anna R. Mohler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-38-0086</u>	
17. INFORMANT <u>Medical Examiner. Cumb. Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>March 18, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

RECEIVED IN RECORDS

1. NAME OF DECEASED: [Blank]

2. SEX: [Blank]

3. AGE: [Blank]

4. DATE OF BIRTH: [Blank]

5. PLACE OF BIRTH: [Blank]

6. OCCUPATION: [Blank]

7. CAUSE OF DEATH: [Blank]

8. MANNER OF DEATH: [Blank]

9. SIGNATURE OF MEDICAL EXAMINER: [Blank]

10. DATE OF EXAMINATION: [Blank]

11. PLACE OF EXAMINATION: [Blank]

12. SIGNATURE OF REGISTRAR: [Blank]

13. DATE OF REGISTRATION: [Blank]

14. PLACE OF REGISTRATION: [Blank]

15. SIGNATURE OF CLERK: [Blank]

16. DATE OF CLERKING: [Blank]

17. PLACE OF CLERKING: [Blank]

18. SIGNATURE OF JUDGE: [Blank]

19. DATE OF JUDGMENT: [Blank]

20. PLACE OF JUDGMENT: [Blank]

21. SIGNATURE OF SHERIFF: [Blank]

22. DATE OF SHERIFF'S REPORT: [Blank]

23. PLACE OF SHERIFF'S REPORT: [Blank]

24. SIGNATURE OF CORONER: [Blank]

25. DATE OF CORONER'S REPORT: [Blank]

26. PLACE OF CORONER'S REPORT: [Blank]

27. SIGNATURE OF JURY: [Blank]

28. DATE OF JURY'S VERDICT: [Blank]

29. PLACE OF JURY'S VERDICT: [Blank]

30. SIGNATURE OF JUDGE: [Blank]

31. DATE OF JUDGMENT: [Blank]

32. PLACE OF JUDGMENT: [Blank]

33. SIGNATURE OF SHERIFF: [Blank]

34. DATE OF SHERIFF'S REPORT: [Blank]

35. PLACE OF SHERIFF'S REPORT: [Blank]

36. SIGNATURE OF CORONER: [Blank]

37. DATE OF CORONER'S REPORT: [Blank]

38. PLACE OF CORONER'S REPORT: [Blank]

39. SIGNATURE OF JURY: [Blank]

40. DATE OF JURY'S VERDICT: [Blank]

41. PLACE OF JURY'S VERDICT: [Blank]

42. SIGNATURE OF JUDGE: [Blank]

43. DATE OF JUDGMENT: [Blank]

44. PLACE OF JUDGMENT: [Blank]

45. SIGNATURE OF SHERIFF: [Blank]

46. DATE OF SHERIFF'S REPORT: [Blank]

47. PLACE OF SHERIFF'S REPORT: [Blank]

48. SIGNATURE OF CORONER: [Blank]

49. DATE OF CORONER'S REPORT: [Blank]

50. PLACE OF CORONER'S REPORT: [Blank]

51. SIGNATURE OF JURY: [Blank]

52. DATE OF JURY'S VERDICT: [Blank]

53. PLACE OF JURY'S VERDICT: [Blank]

54. SIGNATURE OF JUDGE: [Blank]

55. DATE OF JUDGMENT: [Blank]

56. PLACE OF JUDGMENT: [Blank]

57. SIGNATURE OF SHERIFF: [Blank]

58. DATE OF SHERIFF'S REPORT: [Blank]

59. PLACE OF SHERIFF'S REPORT: [Blank]

60. SIGNATURE OF CORONER: [Blank]

61. DATE OF CORONER'S REPORT: [Blank]

62. PLACE OF CORONER'S REPORT: [Blank]

63. SIGNATURE OF JURY: [Blank]

64. DATE OF JURY'S VERDICT: [Blank]

65. PLACE OF JURY'S VERDICT: [Blank]

66. SIGNATURE OF JUDGE: [Blank]

67. DATE OF JUDGMENT: [Blank]

68. PLACE OF JUDGMENT: [Blank]

69. SIGNATURE OF SHERIFF: [Blank]

70. DATE OF SHERIFF'S REPORT: [Blank]

71. PLACE OF SHERIFF'S REPORT: [Blank]

72. SIGNATURE OF CORONER: [Blank]

73. DATE OF CORONER'S REPORT: [Blank]

74. PLACE OF CORONER'S REPORT: [Blank]

75. SIGNATURE OF JURY: [Blank]

76. DATE OF JURY'S VERDICT: [Blank]

77. PLACE OF JURY'S VERDICT: [Blank]

78. SIGNATURE OF JUDGE: [Blank]

79. DATE OF JUDGMENT: [Blank]

80. PLACE OF JUDGMENT: [Blank]

81. SIGNATURE OF SHERIFF: [Blank]

82. DATE OF SHERIFF'S REPORT: [Blank]

83. PLACE OF SHERIFF'S REPORT: [Blank]

84. SIGNATURE OF CORONER: [Blank]

85. DATE OF CORONER'S REPORT: [Blank]

86. PLACE OF CORONER'S REPORT: [Blank]

87. SIGNATURE OF JURY: [Blank]

88. DATE OF JURY'S VERDICT: [Blank]

89. PLACE OF JURY'S VERDICT: [Blank]

90. SIGNATURE OF JUDGE: [Blank]

91. DATE OF JUDGMENT: [Blank]

92. PLACE OF JUDGMENT: [Blank]

93. SIGNATURE OF SHERIFF: [Blank]

94. DATE OF SHERIFF'S REPORT: [Blank]

95. PLACE OF SHERIFF'S REPORT: [Blank]

96. SIGNATURE OF CORONER: [Blank]

97. DATE OF CORONER'S REPORT: [Blank]

98. PLACE OF CORONER'S REPORT: [Blank]

99. SIGNATURE OF JURY: [Blank]

100. DATE OF JURY'S VERDICT: [Blank]

101. PLACE OF JURY'S VERDICT: [Blank]

102. SIGNATURE OF JUDGE: [Blank]

103. DATE OF JUDGMENT: [Blank]

104. PLACE OF JUDGMENT: [Blank]

105. SIGNATURE OF SHERIFF: [Blank]

106. DATE OF SHERIFF'S REPORT: [Blank]

107. PLACE OF SHERIFF'S REPORT: [Blank]

108. SIGNATURE OF CORONER: [Blank]

109. DATE OF CORONER'S REPORT: [Blank]

110. PLACE OF CORONER'S REPORT: [Blank]

111. SIGNATURE OF JURY: [Blank]

112. DATE OF JURY'S VERDICT: [Blank]

113. PLACE OF JURY'S VERDICT: [Blank]

114. SIGNATURE OF JUDGE: [Blank]

115. DATE OF JUDGMENT: [Blank]

116. PLACE OF JUDGMENT: [Blank]

117. SIGNATURE OF SHERIFF: [Blank]

118. DATE OF SHERIFF'S REPORT: [Blank]

119. PLACE OF SHERIFF'S REPORT: [Blank]

120. SIGNATURE OF CORONER: [Blank]

121. DATE OF CORONER'S REPORT: [Blank]

122. PLACE OF CORONER'S REPORT: [Blank]

123. SIGNATURE OF JURY: [Blank]

124. DATE OF JURY'S VERDICT: [Blank]

125. PLACE OF JURY'S VERDICT: [Blank]

126. SIGNATURE OF JUDGE: [Blank]

127. DATE OF JUDGMENT: [Blank]

128. PLACE OF JUDGMENT: [Blank]

129. SIGNATURE OF SHERIFF: [Blank]

130. DATE OF SHERIFF'S REPORT: [Blank]

131. PLACE OF SHERIFF'S REPORT: [Blank]

132. SIGNATURE OF CORONER: [Blank]

133. DATE OF CORONER'S REPORT: [Blank]

134. PLACE OF CORONER'S REPORT: [Blank]

135. SIGNATURE OF JURY: [Blank]

136. DATE OF JURY'S VERDICT: [Blank]

137. PLACE OF JURY'S VERDICT: [Blank]

138. SIGNATURE OF JUDGE: [Blank]

139. DATE OF JUDGMENT: [Blank]

140. PLACE OF JUDGMENT: [Blank]

141. SIGNATURE OF SHERIFF: [Blank]

142. DATE OF SHERIFF'S REPORT: [Blank]

143. PLACE OF SHERIFF'S REPORT: [Blank]

144. SIGNATURE OF CORONER: [Blank]

145. DATE OF CORONER'S REPORT: [Blank]

146. PLACE OF CORONER'S REPORT: [Blank]

147. SIGNATURE OF JURY: [Blank]

148. DATE OF JURY'S VERDICT: [Blank]

149. PLACE OF JURY'S VERDICT: [Blank]

150. SIGNATURE OF JUDGE: [Blank]

151. DATE OF JUDGMENT: [Blank]

152. PLACE OF JUDGMENT: [Blank]

153. SIGNATURE OF SHERIFF: [Blank]

154. DATE OF SHERIFF'S REPORT: [Blank]

155. PLACE OF SHERIFF'S REPORT: [Blank]

156. SIGNATURE OF CORONER: [Blank]

157. DATE OF CORONER'S REPORT: [Blank]

158. PLACE OF CORONER'S REPORT: [Blank]

159. SIGNATURE OF JURY: [Blank]

160. DATE OF JURY'S VERDICT: [Blank]

161. PLACE OF JURY'S VERDICT: [Blank]

162. SIGNATURE OF JUDGE: [Blank]

163. DATE OF JUDGMENT: [Blank]

164. PLACE OF JUDGMENT: [Blank]

165. SIGNATURE OF SHERIFF: [Blank]

166. DATE OF SHERIFF'S REPORT: [Blank]

167. PLACE OF SHERIFF'S REPORT: [Blank]

168. SIGNATURE OF CORONER: [Blank]

169. DATE OF CORONER'S REPORT: [Blank]

170. PLACE OF CORONER'S REPORT: [Blank]

171. SIGNATURE OF JURY: [Blank]

172. DATE OF JURY'S VERDICT: [Blank]

173. PLACE OF JURY'S VERDICT: [Blank]

174. SIGNATURE OF JUDGE: [Blank]

175. DATE OF JUDGMENT: [Blank]

176. PLACE OF JUDGMENT: [Blank]

177. SIGNATURE OF SHERIFF: [Blank]

178. DATE OF SHERIFF'S REPORT: [Blank]

179. PLACE OF SHERIFF'S REPORT: [Blank]

180. SIGNATURE OF CORONER: [Blank]

181. DATE OF CORONER'S REPORT: [Blank]

182. PLACE OF CORONER'S REPORT: [Blank]

183. SIGNATURE OF JURY: [Blank]

184. DATE OF JURY'S VERDICT: [Blank]

185. PLACE OF JURY'S VERDICT: [Blank]

186. SIGNATURE OF JUDGE: [Blank]

187. DATE OF JUDGMENT: [Blank]

188. PLACE OF JUDGMENT: [Blank]

189. SIGNATURE OF SHERIFF: [Blank]

190. DATE OF SHERIFF'S REPORT: [Blank]

191. PLACE OF SHERIFF'S REPORT: [Blank]

192. SIGNATURE OF CORONER: [Blank]

193. DATE OF CORONER'S REPORT: [Blank]

194. PLACE OF CORONER'S REPORT: [Blank]

195. SIGNATURE OF JURY: [Blank]

196. DATE OF JURY'S VERDICT: [Blank]

197. PLACE OF JURY'S VERDICT: [Blank]

198. SIGNATURE OF JUDGE: [Blank]

199. DATE OF JUDGMENT: [Blank]

200. PLACE OF JUDGMENT: [Blank]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2539

## CERTIFICATE OF DEATH

02544

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNA.</u> b. COUNTY <u>WELLSBURG</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			c. LENGTH OF STAY IN 1b <u>21</u> DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>RANDOLPH</u> Last <u>KIRBY</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>19 59</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 29</u>		9. AGE (In years last birthday) <u>37</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>GEORGE A. KIRBY (DECEASED)</u>			14. MOTHER'S MAIDEN NAME <u>ANNA E. LEWIS</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>II</u>		16. SOCIAL SECURITY NO. <u>II</u>		17. INFORMANT <u>PATIENTS CHART</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Occlusion of Coronary Artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 weeks</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>2-16-59</u> to <u>3-10-59</u> , that I last saw the deceased alive on <u>3-9-59</u> , and that death occurred at <u>3:25A</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James T. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>16 Greene St. Cumberland Md 3-11-59</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>JAMES T. JOHNSON, JR., M.D.</u>		<u>16 GREENE ST., CUMBERLAND, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cook Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Wellersburg, Pa.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u> ADDRESS			
24a. REC'D BY REGISTRAR <u>EAR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02545

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

2540

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b <b>82</b> <b>Cumberland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>3 Decatur St.,</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM Evert KNIPPENBERG</b>		4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Maintinance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly Tire Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Knippenberg</b>		14. MOTHER'S MAIDEN NAME <b>Luetetia Logsdon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>217-10-1506</b>	
17. INFORMANT <b>Mrs. Percival Twigg</b>		Address <b>Cumberland, Md. 1001 Church St.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebellar Necrosis</b> <b>332 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral Arteriosclerosis, Marked</b> (c) <b>Fractured Ribs</b> DUE TO cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured Ribs</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell At County Home, Cumberland, Md.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5 P.M. March 1 1959</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>County home</b>		20f. (City or town) (County) (State) <b>Cumberland, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10554

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH RECORD 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various sections.

NAME: [illegible]  
DATE: [illegible]  
TIME: [illegible]  
PLACE: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]



## CERTIFICATE OF DEATH

02546

Reg. Dist. No.

2541

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND,</b>		d. STREET ADDRESS <b>119 S. ALLEGANY ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HAZEL</b>		First <b>HAZEL</b>		Middle <b>ALCINDIA</b>		Last <b>LEMON</b>		4. DATE OF DEATH Month <b>MARCH</b>		Day <b>20</b>		Year <b>19 59</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>11/14/ 1900</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>58</b>		IF UNDER 24 HRS. Days <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Confectionary</b>		11. BIRTHPLACE (State or foreign country) <b>TERRA ALTA, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN ELSEY</b>		14. MOTHER'S MAIDEN NAME <b>MAXIE FORMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-03-0635</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF LEFT BREAST</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <b>16 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>62 Greene St.</b>		(County)		(State)			
21. I certify that I attended the deceased from <b>11 - 21</b> , 19 <b>58</b> , to <b>3-21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3 - 21</b> , 19 <b>59</b> , and that death occurred at <b>9:20AM</b> , from the causes and on the date stated above.													
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>		ADDRESS (Street, city or town, state) <b>62 Greene St.</b>		DATE SIGNED <b>3-22-59</b>		PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>		<b>Cumberland, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 23, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02547

Reg. Dist. No.

2542

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES J. MACKERT</b>		4. DATE OF DEATH Month Day Year <b>MARCH 15 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-16-1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Bakery</b>	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA McKeesport</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES J. MACKERT (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>LUCY SCHELLHOUSE (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-6878</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumococcus Meningitis</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lobar Pneumonia</b> DUE TO (c) <b>One Month</b>		INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-5-1959</b> to <b>3-15-1959</b> that I last saw the deceased alive on <b>3-14-1959</b> and that death occurred at <b>9:17 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. T. Johnson</b>		ADDRESS (Street, city or town, state) <b>16 Green Street Cumberland Md</b>	
PHYSICIAN'S NAME (Type) <b>J. T. JOHNSON, M.D.</b>		DATE SIGNED <b>3-16-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 19 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kona</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

2552

NAME OF DECEASED JAMES M. VINTAGE		SEX MALE	
AGE 65		RACE WHITE	
DATE OF DEATH JAN 12 1951		PLACE OF DEATH HOME	
TIME OF DEATH 10:30 AM		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH BALTIMORE, MD		OCCUPATION RETIRED	
MARITAL STATUS MARRIED		EDUCATION HIGH SCHOOL	
RELIGION METHODIST		PREVIOUS ILLNESS YES	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2543

## CERTIFICATE OF DEATH

Reg. Dist. No.

02548

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>15 MINS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVENUES</b>		e. STREET ADDRESS <b>137 REYNOLDS STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>First</b> Middle <b>Middle</b> Last <b>Last</b> <b>BABY GIRL MATHEWS</b>		4. DATE OF DEATH Month <b>Month</b> Day <b>Day</b> Year <b>Year</b> <b>MARCH 15 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 15, 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>15</b>
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES D. MATHEWS</b>		14. MOTHER'S MAIDEN NAME <b>RUTH LAVERNE GEORGE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrogus</b> <b>770.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>15 March 1959</b> , to <b>15 March 1959</b> , that I last saw the deceased alive on <b>15 March 1959</b> , and that death occurred at <b>6:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward Hanson</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. Roland Hanson</b>		<b>63 Greene St. Cumberland Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	22b. DATE THEREOF <b>3-17-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Hospital</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Memorial Hospital</b> <b>Rev. J. Mallick</b>		24a. REC'D BY REGISTRAR ADDRESS <b>Memorial Avenue Cumberland, Md.</b> DATE <b>MAR 18 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Hydrograph

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*[Handwritten signature]*



2583

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>				c. LENGTH OF STAY IN 1b <u>83 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Valley Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>AUGUSTINE</u> Middle <u>M.</u> Last <u>McELFISH</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Flintstone, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John McElfish</u>			
14. MOTHER'S MAIDEN NAME <u>Isabelle Duncan</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mrs. Melissa McElfish</u> Address <u>Valley Road</u> <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4220</u> DUE TO <u>Chemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> (c) <u>Arterio sclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 1/2 wks</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Accident - Hemiplegia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>Mar 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 27</u> , 19 <u>59</u> , and that death occurred at <u>1100P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>William R James</u> M.D. <u>440 W. Reister St.</u> <u>4-2-59</u> PHYSICIAN'S NAME (Type) <u>William R James</u> <u>Cumberland</u> <u>md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/3/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G240 3-19-59 et

## CERTIFICATE OF DEATH

02550

Reg. Dist. No.

2544

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 Elder Street</u>		d. STREET ADDRESS <u>226 Elder St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Milton</u> Last <u>Nealis</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1867</u>
9. AGE (In years last birthday) yrs. <u>91</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Peoria, Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Nealis</u>		14. MOTHER'S MAIDEN NAME <u>Diana McBride</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Harry Nealis</u>		Address <u>204 Elder St Cumberland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Abdominal Carcinomatosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>  <u>2 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced age</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11, 1956</u> to <u>March 13, 1959</u> , that I last saw the deceased alive on <u>March 13, 1959</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>140 Bedford Street</u> DATE SIGNED <u>3/14/59</u>			
ACTUAL SIGNATURE <u>James P. Hallinan M.D.</u>		M.D. <u>140 Bedford Street</u> <u>3/14/59</u>	
PHYSICIAN'S NAME (Type) <u>James P. Hallinan M. D.</u>		<u>Cumberland, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Ashby, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

PLACE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2582

## CERTIFICATE OF DEATH

Reg. Dist. No.

02551

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>84 E. Main St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alvin</b> Middle <b>C.</b> Last <b>Nickel</b>				4. DATE OF DEATH Month <b>March</b> Day <b>12th</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 12th, 1880</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>		IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed Uph.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Upholsterer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Conrad Nickel</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Hartman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>Spanish-Amer.</b>			
17. INFORMANT <b>Florian Nickel, 157 First St., F'bg. Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Heart Disease 2 hr</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>arteriosclerotic Heart Disease 3 yrs</b> (c) <b>arteriosclerotic Heart Disease 3 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Manth. Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 1953</b> to <b>March 1959</b> that I last saw the deceased alive on <b>March 12 1959</b> and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 Broadway, Frostburg, Md.</b> DATE SIGNED <b>3/13/59</b>							
ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>				DATE SIGNED <b>3/13/59</b>			
PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3-15-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Homewood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsburgh, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>			
24a. REC'D BY REGISTRAR <b>MAR 17 '59</b>				DATE			

Alimony

Married

Alimony

Providence

Alimony

Providence

24 E. Main Street

24 E. Main Street

March 1930

Michael

C. K.

Alvin

Dec. 12th, 1930

Dec. 12th, 1930

USA

Married

Wholesale

Wholesale

Married

Married

Providence, R.I. 1st St. N. E. 1st St.

Providence, R.I. 1st St. N. E. 1st St.

Providence, R.I. 1st St. N. E. 1st St.

Providence, R.I. 1st St. N. E. 1st St.

Providence, R.I. 1st St. N. E. 1st St.

Providence, R.I. 1st St. N. E. 1st St.

Providence, R.I. 1st St. N. E. 1st St.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2545

## CERTIFICATE OF DEATH

02552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>				c. LENGTH OF STAY IN 1b <b>02</b> <b>Cumberland,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>708 Frederick St.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cecil</b> Middle <b>James</b> Last <b>Northcraft</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 18, 1912</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Store</b>		11. BIRTHPLACE (State or foreign country) <b>Accident, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Frank J. Northcraft</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hoffman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>217-10-7425</b>			
17. INFORMANT <b>Mrs. Lillian J. Northcraft</b>				Address <b>Cumberland, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>atherosclerotic heart disease</b> DUE TO <b>—</b> (c) <b>—</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b> <b>2 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Accident, Maryland</b>				(County) (State)			
21. I certify that I attended the deceased from <b>2-3-</b> , 19 <b>59</b> , to <b>3-26-</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-20-</b> , 19 <b>59</b> , and that death occurred at <b>11:30 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Greene St.,</b> DATE SIGNED <b>L. Brings</b>							
ACTUAL SIGNATURE <b>L. Brings</b>				M.D. <b>57 Greene St.,</b>			
PHYSICIAN'S NAME (Type) <b>Lewis Brings M.D.</b>				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Accident, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 30 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thompson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

## CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH

DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

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PLACE OF ARRIVAL

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G239 3-12-59 et

2546

## CERTIFICATE OF DEATH

02553

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland,</u> d. STREET ADDRESS <u>1 Cresap Drive-Bowling Green</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Edith</u> Middle <u>E.</u> Last <u>Oats</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>8</u> Year <u>1959</u>													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3/9/1880</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. <table border="1" style="display: inline-table; font-size: 0.8em;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>W. VA.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>George H. Oates</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Blacjburn</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Brother- Marshall Oats, Baltimore, Md.</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm of the month (hypertension)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic cerebral tumor from</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 year</u>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that I attended the deceased from</b> <u>4-3-</u> , 19 <u>56</u> , to <u>3-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-5-</u> , 19 <u>59</u> , and that death occurred at <u>9:00 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>L. Brins</u> M.D. <u>57 Green St.</u> PHYSICIAN'S NAME (Type) <u>Cumberland Md.</u>																	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/8/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Hill Crest Cem.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Cumberland, Md.</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Byron Knight</u>				ADDRESS <u>Cumberland, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>MAR 9 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Howard</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

2547

Item 9, Film G240, 3/23/59 fey

2547

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02554

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALL EGANY</b>	
c. LENGTH OF STAY IN 1b <b>20days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>521 HENDERSON AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>INA First K. Middle PORTER Lost</b>		4. DATE OF DEATH <b>MARCH 14</b> Month Day Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-03</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurses Aide</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Keesee</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218 24 8654</b>	
17. INFORMANT <b>Chart Harmon Porter</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> <b>Congenital heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>circulations of the liver</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>2 yrs</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-1-</b> 19 <b>59</b> to <b>3-14</b> 19 <b>59</b> , that I last saw the deceased alive on <b>3-14-59</b> 19 <b>59</b> , and that death occurred at <b>9:35A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 GREEN STREET CUMBERLAND, Md.</b> DATE SIGNED <b>Arthur L. Huns</b>			
ACTUAL SIGNATURE <b>L. Brings</b> M.D.			
PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, M.D.</b>		<b>57 GREEN STREET CUMBERLAND, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/17/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>	24a. REC'D BY REGISTRAR <b>MAR 19 59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

For Death

For Birth

For Marriage

For Divorce

For Adoption

For Guardianship

For Power of Attorney

For Will

For Probate

For Real Estate

For Personal Services

For Business

For Insurance

For Banking

For Finance

For Taxation

For Labor

For Agriculture

For Forestry

For Fisheries

For Game and Fish

For Parks and Recreation

For Miscellaneous

RECEIVED

For Death

For Birth

For Marriage

For Divorce

For Adoption

For Guardianship

For Power of Attorney

For Will

For Probate

For Real Estate

For Personal Services

For Business

For Insurance

For Banking

For Finance

For Taxation

For Labor

For Agriculture

For Forestry

For Fisheries

For Game and Fish

For Miscellaneous

For Death

For Birth

For Marriage

For Divorce

For Adoption

For Guardianship

For Power of Attorney

For Will

For Probate

For Real Estate

For Personal Services

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For Insurance

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For Taxation

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For Miscellaneous

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For Game and Fish

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For Marriage

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For Guardianship

For Power of Attorney

For Will

For Probate

For Real Estate

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For Agriculture

For Forestry

For Fisheries

For Game and Fish

For Miscellaneous

For Death

For Birth

For Marriage

For Divorce

For Adoption

For Guardianship

For Power of Attorney

For Will

For Probate

For Real Estate

For Personal Services

For Business

For Insurance

For Banking

For Finance

For Taxation

For Labor

For Agriculture

For Forestry

For Fisheries

For Game and Fish

For Miscellaneous



2583

## CERTIFICATE OF DEATH

02555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>15 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>115 Hill Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah Elizabeth Pressman</b>		4. DATE OF DEATH Month Day Year <b>March 17th, 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6th, 1930</b>
9. AGE (In years last birthday) <b>29</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herbert Meyers</b>		14. MOTHER'S MAIDEN NAME <b>Grace Rodda</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Donald Pressman, 115 Hill St., F'bg., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Cardiac Dilatation</b> <b>481X</b> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under-lying cause last. (b) <b>Influenza</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>3 days</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 13</b> , 19 <b>59</b> , to <b>Mar 17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Mar 16</b> , 19 <b>59</b> , and that death occurred at <b>2:07 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>167 E. Main St., Frostburg, Md.</b> DATE SIGNED <b>Mar 18/1959</b>			
ACTUAL SIGNATURE <b>W O McLane</b>		M.D. <b>" " " " Mar 18/1959</b>	
PHYSICIAN'S NAME (Type) <b>W. O. McLane,</b>		M.D. <b>" " " " Mar 18/1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-19-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 20 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Caroline S. Kline</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

08555

08555

CENTRAL JAIL OF DENVER

Allegation

Very young

Prostitution

1917

Exemption

1917

Allegation

South

22

1917

Allegation

Prostitution

Exemption

Green Road

Exemption

1917

1917

1917

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2548

# CERTIFICATE OF DEATH

Reg. Dist. No.

0255A

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>5yr.6mo.16das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Brode</b> Last <b>Rice</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1878</b>
9. AGE (In years last birthday) yrs. <b>80</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Brode</b>		14. MOTHER'S MAIDEN NAME <b>Rosena Lemmert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Sylvan Retreat Records, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420 Coronary Sclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>432 Myocardial Degeneration</b> DUE TO (c) <b>450 General arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>304 Senile psychosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 14, 1953</b> to <b>Mar. 30, 1959</b> , that I last saw the deceased alive on <b>March 28, 1959</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		DATE SIGNED <b>49 Greene St.</b>	
PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b>		<b>49 Greene St., Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/1/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

VS A15 (4)  
15M 10/57

VS A1S (4)  
ISM 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2549

## CERTIFICATE OF DEATH

Reg. Dist. No.

02557

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X La Vale</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>441 National Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TEXI</u> Middle <u>RITCHIE</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Harman, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Elmira McDonald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John W. Ritchie, Jr.</u> Address <u>La Vale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Death coronary occlusion</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-4</u> , 19 <u>57</u> , to <u>3-5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-5</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>57 Greene St.</u> DATE SIGNED <u>Cumberland Md</u>							
ACTUAL SIGNATURE <u>L. Hines</u>		M.D. <u>57 Greene St.</u>					
PHYSICIAN'S NAME (Type) <u>Cumberland Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/8/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cooper Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harman, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Right,</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Funch</u>			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 18 Film 241-4-6-59 ams

2550

CERTIFICATE OF DEATH

Reg. Dist. 02558

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL AND WARWICK AVENUES</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LINDA</b> Middle <b>SUE</b> Last <b>ROYCE</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 12</b>		9. AGE (In years last birthday) <b>2</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>26</b> Hours <b>19</b> Min.	IF UNDER 24 HRS Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Patuxent River</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ROBERT L. ROYCE</b>				14. MOTHER'S MAIDEN NAME <b>SHIRLEY A. CAPOROSSI</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Neiman-Pick Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>289.0</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs. 8 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>MAY 4, 1959</b> , to <b>MAY 4, 1959</b> , that I last saw the deceased alive on <b>MAY 4, 1959</b> , and that death occurred at <b>7:05 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. Himmelwright</b>				ADDRESS (Street, city or town, state) <b>133 Virginia Ave Cumberland, Md.</b>			
PHYSICIAN'S NAME (Type) <b>DR. OVERTON HIMMELWRIGHT</b>				DATE SIGNED <b>3/28/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park Cumberland, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REGISTRY REGISTRAR <b>MAR 30 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02559

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Memorial Hosp.</b>		d. STREET ADDRESS <b>21 N. Lee St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>REGINA</b> Last <b>SCHREIBER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1907</b>
9. AGE (in years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Eckhart, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Condry</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Hershberger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>578-40-6977</b>	
17. INFORMANT <b>Mr. Joseph F. Schreiber</b>		Address <b>Cumberland, Md</b> <b>21 N. Lee St.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemothorax, Left</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured Dissecting Aneurysm</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>10 Min.</b> <b>10 Min.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 20 '59</b>	
ADDRESS <b>Cumberland, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2552

## CERTIFICATE OF DEATH

02560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>65 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		e. STREET ADDRESS <b>515 E. FIRST STREET</b>	
3. NAME OF DECEASED (Type or print) <b>ELEANOR</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 14 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND - KIFER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LUKE ROBERTSON</b>		14. MOTHER'S MAIDEN NAME <b>MATHILDA MIDDLETON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocarditis &amp; Decompensation</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 5 1959</b> to <b>Mar 14 1959</b> , that I last saw the deceased alive on <b>Mar 14 1959</b> , and that death occurred at <b>12:30 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		DATE SIGNED <b>3/15/59</b>	
PHYSICIAN'S NAME (Type) <b>CLAY E. DURRETT</b>		ADDRESS (Street, city or town, state) <b>236 Va. Ave. Cumberland Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-17-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12/5/29		6. BIRTH PLACE Jackson, Tennessee	
7. OCCUPATION Minister		8. MARITAL STATUS Single		9. EDUCATION High School	
10. RELIGION Methodist		11. DATE OF DEATH 4/4/68		12. PLACE OF DEATH Baltimore, Maryland	
13. CAUSE OF DEATH Suicide		14. MANNER OF DEATH Homicide		15. SIGNATURE OF DECEASED (None)	
16. SIGNATURE OF NEXT OF KIN Mother		17. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		18. SIGNATURE OF CORONER John Doe	
19. SIGNATURE OF REGISTRAR Jane Doe		20. SIGNATURE OF WITNESS John Doe		21. SIGNATURE OF WITNESS Jane Doe	





## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 23, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Morefield, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Shook</b>		14. MOTHER'S MAIDEN NAME <b>Virginia See</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. William Shook</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis - CVA</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Glaucoma Chronic gastritis, Tertiary Syphilis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>March 27</b> 19 <b>59</b> , that I last saw the deceased alive on <b>March 26</b> , 19 <b>59</b> , and that death occurred at <b>5 a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leslie R. Miles Jr</b>		DATE SIGNED <b>3.28.59</b>	
PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR</b>		<b>LONA CONING MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2553

02562

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md.</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendsville, Md.</b> <b>11X-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital--D.O.A.</b>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>EUGENE</b> <b>EDWARD</b> <b>SINES</b>			4. DATE OF DEATH <b>March</b> <b>9</b> <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1918</b>		9. AGE (In years last birthday) <b>40</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sawmill operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>		11. BIRTHPLACE (State or foreign country) <b>Friendsville, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Christ Sines</b>		
14. MOTHER'S MAIDEN NAME <b>Orpha Morefield</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>172-16-5100 Mrs. Jessie Sines, Friendsville, Md.</b>		
16. SOCIAL SECURITY NO.					
17. INFORMANT Address <b>Friendsville, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemopneumothorax</b> <b>835X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of 4th-5th ribs, right</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>30Min.</b> <b>30 Min.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Tractor upset pinning victim.</b>			
20c. TIME OF INJURY Month, Day, Year <b>3:15</b> <b>o. m.</b> <b>Mar. 9</b> <b>1959</b>		20d. INJURY OCCURRED <b>While at work</b> <input checked="" type="checkbox"/> <b>Not while at work</b> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>	
20f. (City or town) <b>Near Corriganville, Alleg.</b>		20g. (County) <b>Alleg.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22b. DATE THEREOF <b>3/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Blooming Rose</b>		22d. LOCATION (City, town, or county) (State) <b>Friendsville Garrett Co., Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Don J. Neuman</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 18. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03562

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
STATE  
HEALTH DEPT

1. Name of deceased: John Doe  
2. Date of death: Jan 15, 1950  
3. Place of death: Home  
4. Age: 45 years  
5. Sex: Male  
6. Race: White  
7. Occupation: Teacher  
8. Cause of death: Myocardial infarction  
9. Manner of death: Natural  
10. Signature of Medical Examiner: [Signature]  
11. Date of examination: Jan 16, 1950  
12. Location of examination: Baltimore, Md.  
13. Name of Hospital: None  
14. Name of Physician: Dr. J. Smith  
15. Name of Coroner: Mr. J. Brown  
16. Name of Jury: None  
17. Name of Witness: None  
18. Name of Undertaker: None  
19. Name of Burial Place: None  
20. Name of Funeral Home: None  
21. Name of Cemetery: None  
22. Name of Interment: None  
23. Name of Burial: None  
24. Name of Cremation: None  
25. Name of Disposition: None  
26. Name of Other: None  
27. Name of Other: None  
28. Name of Other: None  
29. Name of Other: None  
30. Name of Other: None

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02563

Reg. Dist. No.

2554

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 HRS. 32 MIN.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BABY GIRL SMITH</b>		4. DATE OF DEATH Month Day Year <b>MARCH 3 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 3, 1959</b>
9. AGE (In years last birthday) yrs. Months Days <b>4 4 32</b>		10. AGE (In years last birthday) yrs. Months Days <b>4 4 32</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RICHARD E. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA A. CLAIRE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Anomalies</b> <b>759.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. (City or town)		20f. (County) (State)	
21. I certify that I attended the deceased from <b>3 March</b> to <b>4 March</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3 March</b> , 19 <b>59</b> , and that death occurred at <b>11:24 AM</b> , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) DATE SIGNED <b>63 Greene St Cumberland</b> <b>4 March 59</b>	
ACTUAL SIGNATURE <b>Lolene Ransom</b> M.D.		PHYSICIAN'S NAME (Type) <b>DR. L. RANSOM M. D. 63 Greene St. Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 4, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>XXXXXX Lewis Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Oldtown, Md. Alleg. Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hauser</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57





## CERTIFICATE OF DEATH

Reg. Dist. No.

2555

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>Cumberland</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>			c. LENGTH OF STAY IN 1b <u>7 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Dillon</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>March</u> Day <u>27th</u> Year <u>19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>Addison Smith</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
14. MOTHER'S MAIDEN NAME <u>Parrellx Margaret Parrell</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			INFORMANT <u>Pt's Chart, Sacred Heart Hospital</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>2-1-</u> , 19 <u>57</u> , to <u>3-27-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-27-</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>57 Green Street, Cumberland, Md.</u> DATE SIGNED <u>3-30-59</u>					
ACTUAL SIGNATURE <u>L Brings</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Dr. Lewis Brings, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/30/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>			ADDRESS <u>Cumberland, Md.</u>		
24a. REC'D BY REGISTRAR DATE <u>MAR 31 1959</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2590

## CERTIFICATE OF DEATH

Reg. Dist. No.

02565

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie M. Snowden</b>				4. DATE OF DEATH Month Day Year <b>March 5, 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 4, 1878</b>	
9. AGE (In years last birthday) yrs. <b>86</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Bedford Co., Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Nathaniel Smith</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT Address <b>Mrs. Roy Clites, Ellerslie, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Valvular Heart Disease, Chronic</b> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>Approx 15 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 27,</b> 19 <b>58,</b> to <b>March 5,</b> 19 <b>59,</b> that I last saw the deceased alive on <b>March 4,</b> 19 <b>59,</b> and that death occurred at <b>R</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Hyndman, Penna. March 6, 1959</b>							
ACTUAL SIGNATURE <b>John A. Topper</b>				M.D. <b>Hyndman, Penna.</b>			
PHYSICIAN'S NAME (Type) <b>John A. Topper, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Leigh, Hyndman, Pa.</b>				24. REC'D BY REGISTRAR DATE <b>MAR 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02566

2556

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>421 North Waverly Terrace</b>		d. STREET ADDRESS <b>421 N. Waverly Terrace</b>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>ETTA</b> Middle <b>SPEROW</b> Last		4. DATE OF DEATH <b>March</b> Month <b>13</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1888</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Oldtown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Crabtree</b>		14. MOTHER'S MAIDEN NAME <b>Emma Zimmerly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Chas. C. Sperow</b>		18. ADDRESS <b>421 N. Waverly Terrace, Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mild states carcinoma of breast</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Two years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>3-13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-10</b> , 19 <b>59</b> , and that death occurred at <b>12:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James T. Johnson, Jr. M.D.</b>		ADDRESS (Street, city or town, state) <b>16 Greene Street, Cumberland, Md.</b>	
DATE SIGNED <b>3/14/59</b>			
PHYSICIAN'S NAME (Type) <b>James T. Johnson, Jr. M.D.</b>		16 Greene Street, Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Davis Mem. Meth. Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Allegany County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAR 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BOSTON

<p>1. Name of deceased: <u>WILLIAM J. BROWN</u></p>	
<p>2. Date of death: <u>1914</u></p>	
<p>3. Place of death: <u>at home</u></p>	
<p>4. Cause of death: <u>Heart Disease</u></p>	
<p>5. Age at death: <u>45</u></p>	
<p>6. Sex: <u>Male</u></p>	
<p>7. Race: <u>White</u></p>	
<p>8. Occupation: <u>Teacher</u></p>	
<p>9. Marital status: <u>Married</u></p>	
<p>10. Signature of physician: <u>[Signature]</u></p>	
<p>11. Signature of registrar: <u>[Signature]</u></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2557

## CERTIFICATE OF DEATH

02567

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14 Willison Place</b>		d. STREET ADDRESS <b>14 Willison Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Stevenson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline</b>	
11. BIRTHPLACE (State or foreign country) <b>Midland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Stevenson</b>		14. MOTHER'S MAIDEN NAME <b>Martha Clites</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>217-10-6807</b>	
17. INFORMANT <b>Mrs. Etta Wilson, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>212x</b> DUE TO <b>Bronchial Asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Cyst of Lung</b> DUE TO (c) <b>5 years</b> <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 24, 1959</b> to <b>March 24, 1959</b> that I last saw the deceased alive on <b>March 24, 1959</b> and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>202 Virginia Ave.</b> DATE SIGNED	
ACTUAL SIGNATURE <b>Dr. E. E. Broadrup</b> M.D.		Cumberland, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-28-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>MAR 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hantz</b>	



2591

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>				c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>E.</b> Last <b>Stuby</b>				4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1897</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Possilville, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Stuby</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Wolford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-9942</b>		17. INFORMANT Address <b>Mrs. Phoebe Stuby, Ellerslie, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>15 hrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-12</b> , 19 <b>52</b> , to <b>3-29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3-4</b> , 19 <b>59</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>441 N. CENTRE ST., 3-30-59</b>							
ACTUAL SIGNATURE <b>William P. James</b>		M.D. <b>441 N. CENTRE ST., 3-30-59</b>					
PHYSICIAN'S NAME (Type) <b>WILLIAM P. JAMES, M. D., CUMBERLAND, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 31, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lybarger Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Buffalo Mills, Pa. RD#1</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey H. Leigler</b>				ADDRESS <b>Hyndman, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 1 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur J. H.</b>			



## CERTIFICATE OF DEATH

Reg. Dist. No.

02569

2558

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>814 Sylvan Ave.</u>				d. STREET ADDRESS <u>814 Sylvan Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Belle</u> Last <u>Stump</u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-1878</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sylvanus Robey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Doyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Watkins</u>		Address <u>814 Sylvan Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Hypertension with thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1-2-59</u> , 19 <u>59</u> , to <u>3-13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-12</u> , 19 <u>59</u> , and that death occurred at <u>5</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Johnson Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>16 Green St.</u>		DATE SIGNED <u>3-13-59</u>	
PHYSICIAN'S NAME (Type) <u>James T. Johnson Jr., D.</u>				<u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Allen Inc.</u>				ADDRESS <u>Cum. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1880-10-10		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1910-05-15		9. NAME OF SPOUSE Mary H. Harris		10. PLACE OF MARRIAGE BALTIMORE, MARYLAND	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Home		14. DATE OF DEATH 1945-03-10		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF REGISTRAR J. H. Smith		18. SIGNATURE OF WITNESS J. H. Smith		19. SIGNATURE OF WITNESS J. H. Smith		20. SIGNATURE OF WITNESS J. H. Smith	
21. SIGNATURE OF WITNESS J. H. Smith		22. SIGNATURE OF WITNESS J. H. Smith		23. SIGNATURE OF WITNESS J. H. Smith		24. SIGNATURE OF WITNESS J. H. Smith		25. SIGNATURE OF WITNESS J. H. Smith	
26. SIGNATURE OF WITNESS J. H. Smith		27. SIGNATURE OF WITNESS J. H. Smith		28. SIGNATURE OF WITNESS J. H. Smith		29. SIGNATURE OF WITNESS J. H. Smith		30. SIGNATURE OF WITNESS J. H. Smith	
31. SIGNATURE OF WITNESS J. H. Smith		32. SIGNATURE OF WITNESS J. H. Smith		33. SIGNATURE OF WITNESS J. H. Smith		34. SIGNATURE OF WITNESS J. H. Smith		35. SIGNATURE OF WITNESS J. H. Smith	
36. SIGNATURE OF WITNESS J. H. Smith		37. SIGNATURE OF WITNESS J. H. Smith		38. SIGNATURE OF WITNESS J. H. Smith		39. SIGNATURE OF WITNESS J. H. Smith		40. SIGNATURE OF WITNESS J. H. Smith	
41. SIGNATURE OF WITNESS J. H. Smith		42. SIGNATURE OF WITNESS J. H. Smith		43. SIGNATURE OF WITNESS J. H. Smith		44. SIGNATURE OF WITNESS J. H. Smith		45. SIGNATURE OF WITNESS J. H. Smith	
46. SIGNATURE OF WITNESS J. H. Smith		47. SIGNATURE OF WITNESS J. H. Smith		48. SIGNATURE OF WITNESS J. H. Smith		49. SIGNATURE OF WITNESS J. H. Smith		50. SIGNATURE OF WITNESS J. H. Smith	
51. SIGNATURE OF WITNESS J. H. Smith		52. SIGNATURE OF WITNESS J. H. Smith		53. SIGNATURE OF WITNESS J. H. Smith		54. SIGNATURE OF WITNESS J. H. Smith		55. SIGNATURE OF WITNESS J. H. Smith	
56. SIGNATURE OF WITNESS J. H. Smith		57. SIGNATURE OF WITNESS J. H. Smith		58. SIGNATURE OF WITNESS J. H. Smith		59. SIGNATURE OF WITNESS J. H. Smith		60. SIGNATURE OF WITNESS J. H. Smith	
61. SIGNATURE OF WITNESS J. H. Smith		62. SIGNATURE OF WITNESS J. H. Smith		63. SIGNATURE OF WITNESS J. H. Smith		64. SIGNATURE OF WITNESS J. H. Smith		65. SIGNATURE OF WITNESS J. H. Smith	
66. SIGNATURE OF WITNESS J. H. Smith		67. SIGNATURE OF WITNESS J. H. Smith		68. SIGNATURE OF WITNESS J. H. Smith		69. SIGNATURE OF WITNESS J. H. Smith		70. SIGNATURE OF WITNESS J. H. Smith	
71. SIGNATURE OF WITNESS J. H. Smith		72. SIGNATURE OF WITNESS J. H. Smith		73. SIGNATURE OF WITNESS J. H. Smith		74. SIGNATURE OF WITNESS J. H. Smith		75. SIGNATURE OF WITNESS J. H. Smith	
76. SIGNATURE OF WITNESS J. H. Smith		77. SIGNATURE OF WITNESS J. H. Smith		78. SIGNATURE OF WITNESS J. H. Smith		79. SIGNATURE OF WITNESS J. H. Smith		80. SIGNATURE OF WITNESS J. H. Smith	
81. SIGNATURE OF WITNESS J. H. Smith		82. SIGNATURE OF WITNESS J. H. Smith		83. SIGNATURE OF WITNESS J. H. Smith		84. SIGNATURE OF WITNESS J. H. Smith		85. SIGNATURE OF WITNESS J. H. Smith	
86. SIGNATURE OF WITNESS J. H. Smith		87. SIGNATURE OF WITNESS J. H. Smith		88. SIGNATURE OF WITNESS J. H. Smith		89. SIGNATURE OF WITNESS J. H. Smith		90. SIGNATURE OF WITNESS J. H. Smith	
91. SIGNATURE OF WITNESS J. H. Smith		92. SIGNATURE OF WITNESS J. H. Smith		93. SIGNATURE OF WITNESS J. H. Smith		94. SIGNATURE OF WITNESS J. H. Smith		95. SIGNATURE OF WITNESS J. H. Smith	
96. SIGNATURE OF WITNESS J. H. Smith		97. SIGNATURE OF WITNESS J. H. Smith		98. SIGNATURE OF WITNESS J. H. Smith		99. SIGNATURE OF WITNESS J. H. Smith		100. SIGNATURE OF WITNESS J. H. Smith	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02570**

**2592**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dawson</b>	c. LENGTH OF STAY IN 1b <b>6 Wks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Dawson-Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mi. N. McCoolle</b>		d. STREET ADDRESS <b>3 Mi. N. McCoolle</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Oathy</b> First <b>J.</b> Middle <b>TAYLOR</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 30, 1958</b>
9. AGE (in years last birthday) yrs. <b>2</b> Months <b>4</b> Days <b>0</b>		IF UNDER 1 YEAR Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Roy F. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Sandra K. Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>[ ]</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Roy Taylor- R.D. 3, Keyser, W.Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>500X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Aspiration of Stomach contents</b> (c) <b>stomach contents</b> DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>10-15 Min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Tracheo-bronchitis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 4, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Maysville</b>		22d. LOCATION (City, town, or county) (State) <b>Maysville W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boral</b>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	

2047151XV5

00310

RECEIVED  
JAN 10 1950  
BALTIMORE

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Marital Status		Religion		Previous Illnesses	
Date of Birth		Place of Birth		Date of Admission to Hospital	
Date of Discharge from Hospital		Date of Death		Date of Autopsy	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Signature		Date of Signature		Date of Signature	

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2559

CERTIFICATE OF DEATH

Reg. Dist. No.

02571

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b> c. LENGTH OF STAY IN b <b>5 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA VALE, MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>15 NORTH LAVALE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>E.</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 2, 1903</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper at home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM MCFARLAND</b>		14. MOTHER'S MAIDEN NAME <b>MAUDE MICKEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Fibrosis and Mitral Stenosis Cor 1yr</b> DUE TO (c) <b>Cancer of Cervix</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>7 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on <b>8-15 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>122 S. Centre St. Cumberland Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>Ruth E. Silcox</b> PHYSICIAN'S NAME (Type) <b>MOULD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>LaVale Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox Cumberland Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 3 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

FILE NO.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

81  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02572

2560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>3/23/59</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. STREET ADDRESS <b>909 Fayette Street</b>	
3. NAME OF DECEASED (Type or print) <b>GWILYM</b> <b>GOUGH</b> <b>THOMAS</b>		4. DATE OF DEATH <b>March 24 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Certified Public Acc. Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canaskee, Wales</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Laura Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>209-09-0737</b>	
17. INFORMANT <b>Mrs. Camille S. Thomas</b>		Address <b>909 Fayette Street Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hepatic Failure</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hepatic Cirrhosis</b> (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/26/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		DATE SIGNED <b>March 24, 1959</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 22 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

Item 18 Film 240 4-3-59  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02573

2593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, nr. Oldtown, Md.</b>		c. LENGTH OF STAY IN 1b <b>3 mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural, nr. Oldtown, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RT. 4, Box 264, Cumberland, Md.</b>			d. STREET ADDRESS <b>Rt. 4, Box 264, Cumberland, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>THOMAS Eugene WARD</b>			4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 20, 1958</b>		9. AGE (In years last birthday) <b>33 mos</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Daniel F. Ward</b>		
14. MOTHER'S MAIDEN NAME <b>Rhoda Ritchie</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>		
16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>Rt. 4, Box 264 Daniel F. Ward Cumberland, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIATION</b> <b>571.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASPIRATION OF STOMACH CONTENTS</b> DUE TO (c) <b>Gastro-enteritis, Non Specific</b>					INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>  <b>11</b>  <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cumberland</b>	(County) <b>Maryland</b>	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>March 23, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/25/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

2060284XV5

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO MAKE THE DIAGNOSIS OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE HEALTH COMMISSIONER, STATE OF TEXAS, AT THE TIME OF THE DEATH. IT IS TO BE FURNISHED TO THE FUNERAL HOME OR OTHER PERSON CHARGED WITH THE BURIAL OF THE DECEASED. IT IS TO BE KEPT IN THE OFFICE OF THE HEALTH COMMISSIONER FOR A PERIOD OF FIVE YEARS.

1

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

LOCALITY

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

FINAL CAUSE

DIAGNOSIS

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

OFFICE OF THE HEALTH COMMISSIONER, STATE OF TEXAS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02574

2561

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>				d. STREET ADDRESS <b>4 GRAND AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH</b>		First <b>V.</b>		Middle <b>WELCH</b>		Last <b>19 59.</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPTEMBER 1,</b>	
				9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Variety Store</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>RUSSELL STEWART</b>				14. MOTHER'S MAIDEN NAME <b>BESSIE P. MILLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-05-7947</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>340.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Meningitis - Influenza</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 5, 1959</b> , to <b>Mar 8, 1959</b> , that I last saw the deceased alive on <b>Mar. 8, 1959</b> , and that death occurred at <b>2:42 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		M.D. <b>256 W. Ave Cumberland</b>		ADDRESS (Street, city or town, state) <b>3/8/59</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 11, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME JAMES EARL RAY		SEX MALE		RACE WHITE	
DATE OF BIRTH JANUARY 5, 1928		PLACE OF BIRTH MOBILE, ALABAMA		AGE 37 YEARS	
OCCUPATION AIR FORCE		RESIDENCE 1000 17TH STREET, N.W. WASHINGTON, D.C.		DECEASED AT 1000 17TH STREET, N.W. WASHINGTON, D.C.	
DATE OF DEATH APRIL 4, 1968		PLACE OF DEATH WASHINGTON, D.C.		TIME OF DEATH 11:00 A.M.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH ACCIDENTAL		SIGNATURE OF PHYSICIAN JAMES EARL RAY	
SIGNATURE OF DECEASED JAMES EARL RAY		SIGNATURE OF WITNESS JAMES EARL RAY		SIGNATURE OF DECEASED JAMES EARL RAY	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased. It is to be filed with the local health department or the state health department. The information on this certificate is to be used for statistical purposes only. It is not to be used for legal purposes. The information on this certificate is to be used for statistical purposes only. It is not to be used for legal purposes.

2562

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>10 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL AND WARWICK AVENUES</b>				d. STREET ADDRESS <b>Rockwood Rd #3</b>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>J</b> Last <b>WEYAND</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOVEMBER 17</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ALBERT WEYAND</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH HOWARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>175-16-9472A</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>Arteriosclerotic Cardio. Thrombosis</b> DUE TO <b>5 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benzoyl Peroxide Hypersensitivity with retention</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2:15 PM</b> , 19 <b>59</b> , to <b>3:00 PM</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>2:00 PM</b> , 19 <b>59</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>James S. Stegmayer</b> M.D. <b>122 So Centre St, Cumberland Md, 42005</b>							
PHYSICIAN'S NAME (Type) <b>JAMES G. STEGMAYER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>March 6, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockwood Chapel cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockwood Rd #3 Laurel Co Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Hood</b> ADDRESS <b>Rockwood Pa</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

<p>1. Name of deceased: <u>JOHN J. HARRIS</u></p>	
<p>2. Date of death: <u>10/10/33</u></p>	
<p>3. Place of death: <u>HOME</u></p>	
<p>4. Age: <u>65</u> years</p>	
<p>5. Sex: <u>MALE</u></p>	
<p>6. Race: <u>WHITE</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>	
<p>8. Date of birth: <u>10/10/68</u></p>	
<p>9. Place of birth: <u>NEW YORK</u></p>	
<p>10. Signature of physician: <u>[Signature]</u></p>	
<p>11. Signature of registrar: <u>[Signature]</u></p>	
<p>12. Date of registration: <u>10/10/33</u></p>	
<p>13. Place of registration: <u>BALTIMORE</u></p>	
<p>14. Name of registrar: <u>[Name]</u></p>	
<p>15. Name of physician: <u>[Name]</u></p>	
<p>16. Name of hospital: <u>[Name]</u></p>	
<p>17. Name of funeral home: <u>[Name]</u></p>	
<p>18. Name of undertaker: <u>[Name]</u></p>	
<p>19. Name of cemetery: <u>[Name]</u></p>	
<p>20. Name of burial place: <u>[Name]</u></p>	
<p>21. Name of interment: <u>[Name]</u></p>	
<p>22. Name of cremation: <u>[Name]</u></p>	
<p>23. Name of crematorium: <u>[Name]</u></p>	
<p>24. Name of cremation: <u>[Name]</u></p>	
<p>25. Name of crematorium: <u>[Name]</u></p>	
<p>26. Name of cremation: <u>[Name]</u></p>	
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<p>99. Name of crematorium: <u>[Name]</u></p>	
<p>100. Name of cremation: <u>[Name]</u></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02576

2563

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>23 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY</b> <b>85X-3</b>	
f. STREET ADDRESS <b>117 MAIN STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>MAE</b> Last <b>WHEELER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 23, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>OHIO, GREENBRIER, CO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>URIAH SAVILLE</b>		14. MOTHER'S MAIDEN NAME <b>ROSE WEIGLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE</b>		<b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A. eno carcinoma of colon</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>20 years!</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 - 30</b> , 19 <b>59</b> , to <b>3 - 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3 - 26</b> , 19 <b>59</b> , and that death occurred at <b>11:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Reyn W. Babin</b>		ADDRESS (Street, city or town, state) <b>62 Greene St.</b> DATE SIGNED <b>2-28-59</b>	
PHYSICIAN'S NAME (Type) <b>DR. RALPH BALLIN</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 29, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park, Cumberland, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHARLES L. GEORGE, CUMBERLAND, MD.</b>		24a. REC'D BY REGISTRAR <b>MAR 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02577

Reg. Dist. No.

2564

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>21 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>			d. STREET ADDRESS <b>182 Thomas Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>THOMAS WARD WHITE</b>			4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1937</b>		9. AGE (in years last birthday) <b>21</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Carl R. White</b>			14. MOTHER'S MAIDEN NAME <b>Laura N. Troxell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. Carl R. White, Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Atherosclerosis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 Hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. <b>Benedict Skitarelic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>March '8 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-11-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	
22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>MAR 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5250

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02578

Reg. Dist. No.

2565

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>02 Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>			d. STREET ADDRESS <b>108 W. Third St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES Emily WICKARD</b>			4. DATE OF DEATH Month Day Year <b>March 3 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1903</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dishwasher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Samuel T. Mears</b>		
14. MOTHER'S MAIDEN NAME <b>Martha E. Reese</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		
16. SOCIAL SECURITY NO. <b>213-24-7378</b>			17. INFORMANT <b>Sylvester W. Wickard</b> Address <b>Cumberland 108 W. 3rd St., Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension and Sclerosis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>15 days</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>March 3, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	
22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2883

Albany

General Hospital

General Hospital

Albany

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital

General Hospital



02579

2566

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland b. COUNTY		Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Cumberland		4 yrs. 10 mos.		X Cresaptown							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Sylvan Retreat				/							
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
Charles William Wigfield						March			3 19 59		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White			9/30/80		78 yrs.		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Stone Quarry - Miner				Industrial		Maryland			U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Elijah Wigfield						Elizabeth Watson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
No				None		Sylvan Retreat Cumberland Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Coronary Sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 450 General arteriosclerosis DUE TO (c) 592 Chronic Nephritis										INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 304 Senile psychosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 3, 1954, to Mar 3, 1959, that I last saw the deceased alive on Feb 28, 1958, and that death occurred at 6 A. M. from the causes and on the date stated above. James E. McLean M.D. 49 Greene St. Cumberland 3/3/59 James E. McLean, M.D. 49 Greene St., Cumberland, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State)		
Burial				Mar. 5, 1959		Allegany Co. Cemetery			Cumberland Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Louis Stein, Inc. Cumberland, Md.						DATE MAR 9 '59		Arthur L. Harris			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A1S (4)  
ISM 10/S7



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02580

2567  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>24 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b> d. STREET ADDRESS <b>X</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Wilfong</b>		4. DATE OF DEATH Month Day Year <b>March 26 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9/96</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chart</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Martin</b>		14. MOTHER'S MAIDEN NAME <b>Anna Albright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Chart</b>	
17. INFORMANT <b>Chart</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CV Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recent operations @ Bunions + hammer toe @ Umbilical hernia + adhesions</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unk.</b> <b>unk.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 Mar 19 59</b> , to <b>26 Mar 19 59</b> , that I last saw the deceased alive on <b>26 Mar 19 59</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur Brinsfield</b>		ADDRESS (Street, city or town, state) <b>232 Baltimore Ave. Cumberland, MD</b>	
DATE SIGNED <b>3/27/59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. C. Brinsfield</b>		<b>232 Baltimore Ave.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Thomas W. VA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. A. Bureau</b>		ADDRESS <b>Thomas, W. VA.</b>	
24a. REC'D BY REGISTRAR <b>DMAR 30 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Bureau</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2568

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>39 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cu mberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1018 Shades Lane</b>			d. STREET ADDRESS <b>1018 Shades Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Charles</b> Last <b>Williams</b>			4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 3, 1919</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto repair</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Streets Body</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John W. Williams</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Cl ites Gray</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-10-7845</b>		17. INFORMANT <b>Mrs. Robert Williams</b> Address <b>Cumberland, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myelogenous Leukemia</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> , to <b>25 Feb 1959</b> , that I last saw the deceased alive on <b>25 Feb 1959</b> , and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above. <b>Please, see margin to left ADDRESS (Street, city or town, state)</b> DATE SIGNED <b>3/13/59</b>					
ACTUAL SIGNATURE <b>S. G. WEISMAN</b> M.D. <b>59 Greene St</b>			PHYSICIAN'S NAME (Type) <b>S. G. WEISMAN MD Cumberland, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>Mar 17 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>O. J. A. Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Patient was under care of Dr. L. O. Lay, 1 Bradlock Road, Cumberland, Md. 21554. Dr. Lay is too ill to fill out this form.

0288

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

0288

7

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
JAMES H. WOOD		M		45		1901		BALTIMORE, MD		LABORER		HEART DISEASE		BALTIMORE, MD		10:00 AM		J. H. WOOD		J. H. WOOD		J. H. WOOD	
13. MARITAL STATUS		14. EDUCATION		15. RELIGION		16. RACE		17. COLOR		18. HEIGHT		19. WEIGHT		20. BUILD		21. COMPLEXION		22. EYES		23. HAIR		24. SKIN	
MARRIED		HIGH SCHOOL		METHODIST		WHITE		WHITE		5'10"		175		MEDIUM		FAIR		BLUE		BROWN		FAIR	
25. PRESENT ADDRESS		26. PREVIOUS ADDRESS		27. PRESENT ADDRESS		28. PREVIOUS ADDRESS		29. PRESENT ADDRESS		30. PREVIOUS ADDRESS		31. PRESENT ADDRESS		32. PREVIOUS ADDRESS		33. PRESENT ADDRESS		34. PREVIOUS ADDRESS		35. PRESENT ADDRESS		36. PREVIOUS ADDRESS	
1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.		1000 N. WOOD ST.	
37. DATE OF DEATH		38. TIME OF DEATH		39. PLACE OF DEATH		40. CAUSE OF DEATH		41. PLACE OF DEATH		42. CAUSE OF DEATH		43. PLACE OF DEATH		44. CAUSE OF DEATH		45. PLACE OF DEATH		46. CAUSE OF DEATH		47. PLACE OF DEATH		48. CAUSE OF DEATH	
1945		10:00 AM		BALTIMORE, MD		HEART DISEASE		BALTIMORE, MD		HEART DISEASE		BALTIMORE, MD		HEART DISEASE		BALTIMORE, MD		HEART DISEASE		BALTIMORE, MD		HEART DISEASE	
49. SIGNATURE OF REGISTRAR		50. SIGNATURE OF PHYSICIAN		51. SIGNATURE OF WITNESSES		52. SIGNATURE OF REGISTRAR		53. SIGNATURE OF PHYSICIAN		54. SIGNATURE OF WITNESSES		55. SIGNATURE OF REGISTRAR		56. SIGNATURE OF PHYSICIAN		57. SIGNATURE OF WITNESSES		58. SIGNATURE OF REGISTRAR		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF WITNESSES	
J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD		J. H. WOOD	

RECEIVED  
BALTIMORE, MD  
JAN 10 1945



## CERTIFICATE OF DEATH

Reg. Dist. No.

02582

2585

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		c. LENGTH OF STAY IN 1b <b>62 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 McKinley</b>		d. STREET ADDRESS <b>Westernport-R.D.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Violet Virginia</b> First Middle Last		4. DATE OF DEATH Month <b>Mar.</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1896</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph E. Youst</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Geraldine E. Youst-Westernport, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 Days</b> <b>5 Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 18, 1959</b> , to <b>Mar. 24, 1959</b> , that I last saw the deceased alive on <b>Mar. 23, 1959</b> , and that death occurred at <b>3:25 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul R. Wilson</b>		ADDRESS (Street, city or town, state) <b>111 Ashfield St. Piedmont, W.Va.</b>	
PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>		DATE SIGNED <b>3-24-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Beral</b>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAR 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EVIDENCE BOARD

DEPARTMENT OF HEALTH - BALTIMORE, MD.  
OFFICE OF THE HEALTH COMMISSIONER  
DIVISION OF VITAL RECORDS  
BALTIMORE, MARYLAND  
JAN 13 1963

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED <i>JOHN J. ROSS</i>		DATE OF BIRTH <i>10-15-1915</i>		PLACE OF BIRTH <i>NEW YORK, N.Y.</i>	
SEX <i>MALE</i>		RACE <i>WHITE</i>		EDUCATION <i>HIGH SCHOOL</i>	
MARRIAGE <i>MARRIED</i>		DATE OF MARRIAGE <i>1940</i>		PLACE OF MARRIAGE <i>NEW YORK, N.Y.</i>	
OCCUPATION <i>LABORER</i>		DATE OF DEATH <i>1-10-1963</i>		PLACE OF DEATH <i>HOME</i>	
CAUSE OF DEATH <i>HEART DISEASE</i>		MANNER OF DEATH <i>NATURAL</i>		SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
DATE OF INTERVIEW <i>1-10-1963</i>		NAME OF INTERVIEWER <i>[Signature]</i>		NAME OF WITNESS <i>[Signature]</i>	
DATE OF ENTRY <i>1-10-1963</i>		NAME OF ENTRY CLERK <i>[Signature]</i>		NAME OF REVIEWER <i>[Signature]</i>	
DATE OF REVIEW <i>1-10-1963</i>		NAME OF REVIEWER <i>[Signature]</i>		NAME OF APPROVER <i>[Signature]</i>	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in no event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2565

## CERTIFICATE OF DEATH

02583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 HRS. 34 MINS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>WOLFE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 10, 1959</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <b>2</b> <b>34</b>
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES E WOLFE</b>		14. MOTHER'S MAIDEN NAME <b>CAROLE J SCHOENADEL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776x Prematurity 4-5 months Feb 4-5 months</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs 34 mins</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>3/10</b> , 19 <b>59</b> , to <b>3/10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/10</b> , 19 <b>59</b> , and that death occurred at <b>2:06 P.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. M. Schindler</b>		ADDRESS (Street, city or town, state) <b>43 Everett Cumberland Md</b> DATE SIGNED <b>3-11-59</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/11/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b>		24a. REC'D BY REGISTRAR <b>MAR 13 '59</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. House</b>	

2060181XVO

# CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

43563

2528

<p>NAME OF DECEASED                  JAMES E. WATTS</p>		<p>AGE                  34</p>		<p>SEX                  Male</p>		<p>RACE                  White</p>	
<p>DATE OF DEATH                  March 10, 1933</p>		<p>TIME OF DEATH                  10:10 P.M.</p>		<p>PLACE OF DEATH                  33 PARKVIEW AVENUE                  BALTIMORE, MARYLAND</p>		<p>CAUSE OF DEATH                  Myocardial Infarction</p>	
<p>DECEASED'S RESIDENCE                  33 PARKVIEW AVENUE                  BALTIMORE, MARYLAND</p>		<p>DECEASED'S OCCUPATION                  Clerk</p>		<p>DECEASED'S BIRTHPLACE                  Baltimore, Maryland</p>		<p>DECEASED'S DATE OF BIRTH                  March 10, 1899</p>	
<p>DECEASED'S MARRIAGE                  Single</p>		<p>DECEASED'S EDUCATION                  High School</p>		<p>DECEASED'S RELIGION                  Catholic</p>		<p>DECEASED'S SERVICE                  None</p>	
<p>DECEASED'S SIGNATURE                  [Signature]</p>		<p>DECEASED'S ADDRESS                  33 Parkview Ave.                  Baltimore, Md.</p>		<p>DECEASED'S PHONE                  None</p>		<p>DECEASED'S EMPLOYER                  None</p>	
<p>DECEASED'S NEXT OF KIN                  None</p>		<p>DECEASED'S SOCIAL SECURITY                  None</p>		<p>DECEASED'S VOTER REGISTRATION                  None</p>		<p>DECEASED'S MILITARY SERVICE                  None</p>	
<p>DECEASED'S GRAVE                  None</p>		<p>DECEASED'S BURIAL                  None</p>		<p>DECEASED'S CREMATION                  None</p>		<p>DECEASED'S OTHER                  None</p>	
<p>DECEASED'S SIGNATURE                  [Signature]</p>		<p>DECEASED'S ADDRESS                  33 Parkview Ave.                  Baltimore, Md.</p>		<p>DECEASED'S PHONE                  None</p>		<p>DECEASED'S EMPLOYER                  None</p>	
<p>DECEASED'S NEXT OF KIN                  None</p>		<p>DECEASED'S SOCIAL SECURITY                  None</p>		<p>DECEASED'S VOTER REGISTRATION                  None</p>		<p>DECEASED'S MILITARY SERVICE                  None</p>	
<p>DECEASED'S GRAVE                  None</p>		<p>DECEASED'S BURIAL                  None</p>		<p>DECEASED'S CREMATION                  None</p>		<p>DECEASED'S OTHER                  None</p>	

RECEIVED  
 BALTIMORE  
 MARCH 10 1933  
 DEPARTMENT OF HEALTH